Interprofessional Healthcare Teams: Inquiry into Performativity Using Applied Theatre

by

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Abstract

My investigation lives in the borderlands of health sciences research where inquiry, nursing and healthcare practices intersect in inter-disciplinary spaces. The relational aspects of nurses and other healthcare practitioners working together with patients is the area of my inquiry into the performance of teams using applied theatre.

Having a non-positivist orientation, this collaborative research is based on the realities of healthcare providers engaged in teams. Participation undergirds arts-based methodologies under which applied theatre is theoretically grounded.

The research is consistent with an open inquiry stance. Reviewed literature is threaded throughout as considerations of the topic, methodology, ethics and analysis arise. Beginning with my own story, I invite the reader into the context of my pursuit of the *we* in interprofessional healthcare team. A narrative introduces the idea of a performative *we* that becomes the frame of multiple questions to address my primary research question, "What is the relational work of interprofessional healthcare teams?"

Interprofessionalism is being intentionally expanded throughout healthcare in response to economic, human resource and patient safety conditions needing to be addressed and such attention is encouraged by the World Health Organization. It is also the focus of practitioners and researchers in expanding networks interested and involved in interprofessionalism throughout the world.

Healthcare team's work and processes are essential components to consider in exploring relationships of individuals brought together interprofessionally to form the team. In this research, healthcare providers participated in co-creating knowledge and understandings

about interprofessional healthcare teams through applied theatre research methods using forum theatre to identify struggles in team practices.

Performativity, seen as both phenomena and methodology, offered exploration of ways in being a team that are theorized through Pickering's theory of the *Mangle of Practice.* Building knowledge with a performative perspective where both humans and non-human agency has a bearing on practices, opens dialogue about the strands of practice situated in what Pickering calls *the mangle of practice*. The strands of organizational influences, accomplishing tasks and an orientation toward care, became apparent as components of the mangle through crafting scenes of a play using forum theatre methods. Acknowledging sociomateriality in interprofessional interactions has a bearing on team practices. Identifying points of struggle by engaging in forum theatre processes, participants pursued a deeper understanding of struggles with structures in healthcare and teamwork, struggles in having competing attentions, and struggles within their own practices.

The outcome of my inquiry makes explicit some of the processes, beliefs and actions that constitute teamwork in healthcare. Employing methods within a participatory approach and performative methodology aligns the inquiry with the nature of the human interactions and performativity that contribute to team performance and ultimately, teamwork.

Preface

This thesis is an original work by Susan Champion Sommerfeldt. The research project included in this thesis received research ethics approval from the University of Alberta Research Ethics Board, for the study entitled "Performing as a Team: The Relational Work of Interprofessional Healthcare Teams", No. Pro00036822, March 12, 2013.

The papers contained in this thesis have been published or have been submitted and are currently being reviewed for publication. Chapter 3 is published as S.C. Sommerfeldt (2013), "Articulating Nursing in an Interprofessional World*," Nurse Education in Practice*, vol. 13, issue 6, 519-523.

Chapter 4 of this thesis is published as S.C. Sommerfeldt, V. Caine, & A. Molzahn (2014), "Considering Performativity as Methodology and Phenomena in Investigating Interprofessional Healthcare Teams" *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* vol. 15, issue 2, article 11. I was responsible for conducting the research study that is used as an example in this manuscript as well as the composition of the manuscript. Dr. V. Caine assisted in a supervisory role and with conceptual formation as well as contributed in organizing and editing the manuscript. Dr. A. Molzahn, also in a supervisory role, contributed to refining the concepts and manuscript edits.

The manuscript contained in Chapter 5 was submitted for consideration as S.C. Sommerfeldt, "In the Mangle of Interprofessional Healthcare Teams: A Performative Study Using Forum Theatre" to the journal *International Journal of Nursing Studies*.

.Dedication

To loving Parents

and

To interprofessional Champions everywhere

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This research came about through the efforts of many. I acknowledge the support, encouragement and guidance of several people, who inspired, taught, challenged and motivated me in my pursuit. Each in their way moved me toward seeking understanding and clearness.

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I particularly note with deep gratitude the steadfast loving encouragement of my husband, Don, who values learning and is an academic to the core. My family is the axis upon which my world revolves. My parents, Alan and Jacqueline Champion, blessed my life with siblings, security and room for curiosity, while my eldest brother introduced the notion of possibilities in academia. My in-law parents are examples of life-long learners, who demonstrated the tenacity and commitment needed for education to trump histories of poverty.

I had the remarkable opportunity of obtaining post-secondary education alongside each of my children. I thank them for the many interprofessional conversations around the kitchen table. Matt (BEd, LLB) and Karen (BScPharm), Rachelle (BScDH) and Dennis (BEd, MEd), Mark (BScPT, MD) and Renée (BScN), Joseph (BScMS, MD) and Stephanie (BSc, BEd), David (BA, MA, JD student), James (undergraduate student) and Maryn (undergraduate student) have shared their educational journeys, experiences and stories. My grandchildren, Tessa, Joshua, Brandt, Claire, Eva, Jacob, Vinessa, Toby, Jonah, Thomas, Laura and Spencer, include me in their loving ways. I extend heartfelt gratitude and love to each family member. My life is blessed by loving relationships with many encouraging friends, and in particular Kimberly Burnham, who joined me in graduate studies, and Dr. Beverley O'Brien, who first pulled me into the domain of healthcare research 14 years ago.

My graduate studies have been supported by a community of saints. I thank them for their faith and trust in me in completing this work. I acknowledge new beginnings in directions yet to be revealed.

Table of Contents

List of Tables

List of Figures

List of Images

Chapter 1: Performing as a Team

Prologue

My doctoral research lives in the borderlands of health sciences research where inquiry, nursing and healthcare practices intersect in inter-disciplinary spaces. The language of theatre can be used to describe the involvement of nurses in the lives of patients[1] as well as their presence in a healthcare team. Competence is partially assessed on how nursing tasks are *performed*. Performance and theatrical metaphors are consistent with the relational human experiences of helping others in their endeavours of advancing health. The relational aspects of teams of nurses and other healthcare practitioners working together forms the basis of my inquiry into the performativity[2] and performance of teams, using applied theatre.

This work is informed through my experiences, as well as critical thought exploring dimensions of care that include power as an influence in relationships. Having a non-positivist orientation places collaborative ways of doing research within a world view that is "based on participation and participative realities" (Heron & Reason, 1997, p. 275). Participation undergirds arts-based research under which applied theatre is theoretically situated.[3] I looked to performance to investigate healthcare teams through my experiences of seeing theatre open places of imagination and where exploring possibilities has potential for new understanding in

[1] For clarity in this document, I refer to the end-user of the healthcare system as a *patient*. I acknowledge that using other signifiers (such as client, consumer, service user) to describe the individual utilizing the system is controversial. Although I recognize the role of population and community health, I restrict the discussion here to individuals. While *patient* is generally used, the word *client* appears in this document in participant quotes or when contextually relevant. Healthcare professionals referred to in this document include all practitioners covered under the Alberta Health Professions Act (Health Professions Act, 2000). The configuration of teams and what constitutes a healthcare team is discussed later in the document.

[2] Performativity is multi-layered and complex phenomena. Each definition of performativity comes with its own limitations. However, to offer the reader a beginning reference point for the concept, I draw on Finley who defines performativity as "is the writing and rewriting of meanings to create a dynamic and open dialogue that continually disrupts the authority of meta-narratives" (Finley, 2011 p. 442). Performativity as phenomena and methodology are discussed in detail in Chapter 5.

[3] I situate my study as arts-based research. Key aspects of this are a participatory perspective consistent with applied theatre techniques, using forum theatre methods that have roots in Theatre of the Oppressed (Boal, 1985).

ways that traditional inquiry methods do not. Needing further training, I completed courses and training in performance theory, discourse analysis, arts-based research, drama theory and Theatre of the Oppressed processes. Partnering with an expert in community theatre research methods offered me the opportunity to branch into performative inquiry to address questions of being a team.

Denzin (2003) suggests that "we inhabit a performance-based, dramaturgical culture" (p.x) where any division between performativity (the *doing*), and performance (the *done*) has vanished (Conquergood, 1998). The inquiry space opened through performance and participation invites methods such as applied theatre as a basis for expanding understanding of human interactions. This study engaged nurses and other healthcare professionals in collaborative research that furthered understanding of working together using forum theatre, a specific applied theatre method developed from the traditions of Theatre of the Oppressed.

Reviewed literature is threaded throughout the dissertation as considerations of the topic, methodology, and analysis arose. Beginning with my own story, I invite the reader into the context of my pursuit of interprofessional healthcare team explorations. This narrative introduces a setting of multiple questions to address my primary research question, "What is the relational work of interprofessional healthcare teams?"

My research brings together distinct ways of exploring an interprofessional healthcare teams: team work. Just as complexity lives alongside patient interactions within the healthcare system, team work has essential components to consider in exploring relationships of individuals brought together to form a team. The roles of each team member are at times obscured through layers of power, expectations, stereotypes, trust, understandings,

personalities and a multitude of factors that contribute to the complicated nature of healthcare interactions.

Performativity, seen as both phenomena and methodology, offered exploration of ways of being a team that are theorized through Pickering's (1995) theory of the *Mangle of Practice.* Pickering explains *mangling* to be the process of human and non-human agency being negotiated through processes of resistance and accommodation. The metaphorical picture of a mangle in an old-fashioned roller washing machine, or the idea of a process being mangled or botched fits with the experiences of team members in sorting out pieces of interprofessional interactions. The pieces of these interactions I have termed *strands,* which are components of team practice and individual contributions to being a team.

Building knowledge with a performative perspective where both humans and non-human agency has a bearing on practices opens dialogue about the strands of practice situated in the mangle. The strands of organizational influence, accomplishing tasks, and an orientation toward care became apparent through crafting scenes of a play using forum theatre methods. Identifying points of struggle, participants pursued a deeper understanding of struggles with structures in healthcare and teamwork, struggles that called for competing attentions, and struggles in their practice itself. In this research I wrestle with the complexity of performance by embodying understandings and facilitating experiences to discover meanings and interpretations of interprofessionalism. The outcome of my inquiry makes explicit the processes, beliefs and actions that contribute to teamwork in healthcare. Employing methods within a participatory approach and art-based research aligns the inquiry with the nature of the human interactions and performativity that contribute to team performance, and ultimately teamwork.

The Early Part of My Story

I begin with a personal story that immersed me in wondering about interprofessionalism and my views about it as a mother and as a nurse. My experiences brought questions about the way in which patients, their families, and healthcare professionals interacted. The questions that I pursued in research began surfacing almost twenty years ago.

> Jas[4] looked cherubic. His Snuffleupagus-like brown eyes fixed on the task at hand while the Speech and Language Pathologist (SLP) continued her pre-school speech assessment. There sat the little guy at a kid-sized table with an unknown friendly adult trying to engage him in conversation. I was observing from behind one-way glass that was disguised as a window in the wall of a clinic examination room. Sitting alone with my presence unknown to Jas in the dark antechamber felt somewhat deceptive to me, like so many things in a grownup's world. I accepted that this reality could be cushioned for a four year-old not knowing he was being watched, even at the expense of the usual transparency we maintained. He was being brave in my absence, unaware that he was being assessed and engrossed in the activity.
>
> The SLP was using small index cards with pictures to administer a Peabody Vocabulary test. I watched Jas' face light up as he identified the objects in the pictures. I listened to the garbled sounds that came from the awkward movements of his lips and tongue producing a word not found in an English dictionary, "Sipshures!"
>
> "What is that?" questioned the SLP.
>
> "Sipshures!" came the confident reply along with a broad grin. I could see the picture and I was familiar with the word that Jas was trying to say.
>
> "Okay." A contemplative pause, then the SLP cautiously continued, "What is this?" She changed the card and the assessment went on.
>
> I mused at the irony – representations of real objects used to elicit specific signifiers. Jas's utterances were not actual English words, yet they were true verbal representations to him, and were comprehensible to me.

[4] This story is told with Jas' knowledge and permission (Jas, personal communication).

Our own language; our own little world, I thought. Our space was being intruded by assessment.

The assessment came about because of my own nursing knowledge of pre-school developmental tasks and a conversation with a community health nurse. This resulted in a request for a consultation with a pediatrician, followed by a further consultation with a developmental pediatrician who asked for a speech assessment. The sequential nature of care that unfolded in our lives created a curiosity about demonstrations of teamwork. I didn't see it at the time. Didn't see how each component of a virtual team participated in teamwork by leaving texts for the next. I was the link, and Jas was the subject. Actually, it seemed as though he was often the object.

Following the assessment, the SLP gave Jas a few toys to play with and came into the observation room to speak to me.

"*We* have a major problem here. His knowledge of basic items is very low and he needs immediate intervention. I'll make the arrangements for community speech intervention…"

I wondered who the *we* was because I knew that I would never see her again.

She continued, "I was amazed, he didn't even know what a 'book' was."

Yes he did, but I felt that I couldn't disclose this. He identified the picture of a book as "sipshures." The photograph on the card was an open book; a representation to which he attached his own signifier. He knew that it was a book and further, that it was a specialized book of scripture – *sipshures* to him. It was the name of holy book that he connected to family and ritual. As a family we read scriptures together, his chubby little fingers traced shapes along the pages while his older siblings read out loud a verse or two. His frame of reference for the book-picture was a family surrounding the kitchen table sharing a few quiet moments together in an oasis of a hectic day. He knew what the picture of an open book signified in his world. This knowledge was a piece of information that would remain private between us as an unspoken token of solidarity. The SLP had no way of knowing and I justified my ambivalence about translating for Jas as his speech was being evaluated.

> After the assessment, I saw myself as standing in the middle between two systems, each competing for my loyalty. On one hand, I needed to acquire system allies in my attempts to equip Jas for success in the world. Clearly his ability to communicate was a hindrance. On the other hand, my motherhood fidelity was threatened and I wanted to shout out, "He knows what a book is!" I wanted to tell his story, but chose to remain still.
>
> My silence felt like betrayal. I knew that the bigger the problem, the more likely interventions would be available. Let them draw their own conclusions, I rationalized. *We* need to access the help.

This first moment of silence was the start of what was to become a pattern of survival in the health and educational systems with Jas and me. It became a strategy in playing my role on this type of team. Parental advocacy by silence evolved into professional advocacy through academia. I enrolled in graduate school to explore inter-disciplinary approaches to children with developmental coordination disorder that often manifests itself with early speech problems. I wondered why systems seemed so disjointed and how a parent could navigate such complexity. How could interprofessional teams operate with less fragmentation? What indeed, comprised and maintained the *we*?

This narrative is the backstory to my work of inquiry with interprofessional teams within the realities of an inter-disciplinary and multi-disciplinary healthcare delivery system. That moment of assessment was a watershed experience in my life that framed my research.

Interprofessional considerations are raised in the story:

- Who is the *we*?
- How are healthcare texts and actions performed?
- What can be discovered about roles and relationships at play in healthcare teams? This question encompasses further questions that elucidate processes in relationships such as: What determines power? What are the boundaries and borderlands of being an

insider or outsider? How is this negotiated intentionally and unintentionally? How do individuals shape larger team perspectives that include patients or families?

The Research Question

The research questions of my study emerged while pondering the implications of *we* and related questions such as: What is the relational work of a healthcare team that influences team performance? How do healthcare providers understand teamwork? Which tensions in working as a team are difficult to talk about? How are tensions resolved? Maintained? What is at stake? Providing clarity in the relational aspects of teams is the first step in identifying variables and outcomes that are unique to healthcare team contexts.

At stake is the perpetuated use of inappropriate organizational models and team practices that overlook essential relational components of teamwork, particularly in considering patients and families as part of the team. Therefore, my overall research question was: "What is the relational work of healthcare teams?"

My research describes some of the interpersonal aspects of team functions and processes involved in forming and maintaining successful healthcare teams. Exploring aspects of communicating, determining and negotiating roles, managing alternative perspectives, valuing or dismissing individual contributions, and developing mechanisms for reflection offer some ways to understand the relationship-building that occurs in healthcare teams.

Through Nursing Eyes

Returning to my story that began the cascading questions about healthcare teamwork, I gaze back through time with nursing eyes and new wonderings. Has the influence of interprofessionalism swayed nursing, or can the profession and discipline of nursing alter the world of healthcare interprofessionalism?

For a nursing influence to be felt in shaping the evolving interprofessional world of healthcare, nurses must engage and be prepared to articulate to others what nursing actually is and what it is not. Nurse educators need curricula that utilize clinical experiences and coursework to build futures in the intentionally expanding interprofessional landscape that awaits students upon their graduation. The Lancet Commission report on transforming the education of health professionals particularly targets professional education as not keeping pace with the increased complexity in the healthcare field. It identifies systemic problems stemming from "fragmented, outdated and static curricula that produce ill-equipped graduates" (Frenk, Chen, et al., 2010, p.1). The recommendations in the report include ensuring transformative learning that allows students to achieve core competencies for effective teamwork in a system that eliminates the "tribalism" or isolation that persists in uni-professional education of health sciences professional training.

Realizing this vision requires an adjusted view of nursing education and professional development. Nurses recognize the need to identify their knowledge and skills in interprofessional work. In 2011, the Canadian Nurses Association (CNA) published a position statement which acknowledged that "(e)ach profession brings its own set of knowledge and skill – the result of education, training, and experience – to collaborative health services […] Shared decision-making, creativity and innovation allow providers to learn from each other and enhance the effectiveness of their collaborative efforts" (CNA, 2011, p. 2). How nurses theorize their work contributes to how they communicate their work to others.

Nursing theory developed in North America throughout the second half of the 20th century. Nelson (2002) argues that the professionalizing discourse shifted from history to nursing theory, leading to an ahistorical nursing science. It seems that theorists influenced nurses' understanding of "who they are, what they do and why" (p.181) through humanistic

philosophies of caring. Nelson suggests this has an effect on how nursing identity is shaped. Distanced from its history, depictions of nursing became a product of theory, rather than from the doing of nursing in practice. Historical knowing informs current frames of nursing identity and provides insight into the consequences of uncontested oppression and hegemonic forces. Current nursing theory needs to create spaces for nurses to understand their performance within interprofessional practice environments.

In exploring contemporary nursing knowledge, Risjord (2010) sides with Meleis (2012) that theory development can bridge this relevancy gap. Meleis (2012) suggests that a post-nursing-theory era needs to focus its attention on the practical needs of nursing in building healthcare theory. Risjord (2010) further expands the idea that practice needs to be reoriented in building nursing knowledge. Meleis (2012) describes the need for future theoretical development in nursing through situation-specific theory that is more consistent with interprofessional nursing practice.

Nursing would be in a stronger position in interprofessional work if the discipline of nursing and the practice of nursing could be reconciled. Dobratz (2010) calls for “shared and valued goals” (p. 66) to bring about a reconnection between theorists and practitioners. Nursing performance, conceptualized and influenced through performance theory (McKenzie, 2001) ties together nursing knowledge and nursing actions that then allows nurses to be clear in explaining what they do. Nursing theory that trickles down from grand theory is removed from theoretical explanations of clinical judgement that a nurse might use in choosing the size of intravenous catheter to start an infusion, given the stability of vital signs warning of potential hypovolemic shock, for example. The performance link between nursing theory and its actual work needs to be included in this reframing.

Clearly, a culture within nursing that supports an identity with encompassed interprofessionality can positively influence healthcare delivery. As interprofessionalism gains momentum, nurses have the opportunity to creatively re-shape healthcare in an innovative and noticeable way. In interprofessional workplaces, clearly defined and valued ways of explaining nurses' work enable individual nurses to have the confidence to explain their roles, supported by reframed practice-relevant theory.

Nurses need to be seen as leaders in healthcare system changes by providing support in interprofessional nursing practice environments. Nurses can demonstrate professionalism by expanding their own interprofessional competence. It is requisite that nursing education equips students for interprofessional practice through closely linked nursing and interprofessional competencies. Preparatory interprofessional learning and identity work can position nursing graduates to perform collaborative and integrated care. Being able to clearly articulate what nurses know and do in their role can be foundational in making nursing visible in the expanding interprofessional healthcare world.

Who Is the *We* in the Performance of Healthcare Teams?

Just as in my experience with Jas, the pursuit of a healthy[5] life leads one through multiple interactions with professionals engaged in the practice and study of the health sciences. Maintaining health and addressing variations in wellbeing brings people together in relationships and systems that are designed to assist in developing health habits or practices and, where necessary, interventions, for optimal health. Nurses are particularly well situated to

[5] *Health* used here reflects a broad description of wellness defined by the World Health Organization as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 2012). Health is defined through family beliefs and practices which at times create tensions in a system aimed at *fixing*.

be integral navigators of the health system, teamed up with others in negotiating health outcomes. This is the basis of health-inspired teamwork: a person, family, community or nation interacting with societal health systems developed with the aim of realizing the goal of health for all (World Health Organization, 1986). The people-interaction point of engagement in health systems is the focus of my research in exploring relationships.

In 2010, the province of Alberta produced a document, *Becoming the Best: Alberta's 5 year Health Action Plan* (Alberta Health and Wellness, 2010), directed at reforming the healthcare system. This document identifies the "unique opportunity to respond to the strategies and concerns of Albertans" (p.1) in the province as one single consolidated health authority reshapes the provincial system. With primary care as a focus, one aim was to increase access to "one or more members of a health-care team," ensuring that Albertans will "receive the right care, from the right person, at the right time" (p.4) with that care being better co-ordinated.

The interplay of healthcare workers is historical. Caring for individuals and attending to the health needs of others is an ancient story found in folklore and early anthropological evidence of human interaction. Formalization of health professions in modern times has roots in the 16th century where craft guilds developed to protect, promote and regulate emerging professions (Reeves, Macmillan, & van Soeren, 2010). As professionalization and scientific knowledge evolved, routes developed to deliver different aspects of care.

Regulation involved defining scopes of practice, which resulted in tensions and questions of leadership in healthcare teamwork. Since the mid-1980s in Canada, factors to improve health outcomes and reconcile spiraling health costs have prompted calls for collaborative ways to practice healthcare.

An appeal for students to be educated and prepared for integrated interprofessional healthcare delivery was first heard in the 1990s. Yet, literature introducing the term

interprofessional (IP), and research elucidating the dimensions of interprofessional and interprofessional education (IPE), was scant at the turn of the 21st century (Reeves, Tassone, Parker, Wagner, & Simmons, 2012). The World Health Organization (WHO) concluded in 2010 that sufficient evidence over 50 years of inquiry supported collaborative modes of care (World Health Organization, 2010) and now calls for "scaling up" educational efforts (World Health Organization, 2013). The 2010 Lancet Commission conducted a comprehensive analysis of health practitioner education and practice in light of current worldwide conditions and needs. The report, *Health Professionals for a New Century: Transforming education to strengthen health systems in an interdependent world* (also called the *Lancet Commission Report*), is quickly becoming a key document in health education and healthcare system reform (Frenk et al., 2010). A Canadian framework for interprofessionalism was developed to support interprofessional competency-based care and education (Canadian Interprofessional Health Collaborative, 2010). It informed the interprofessional competency framework of other countries, such as the United States of America (Schmitt, Blue, Aschenbrener, & Viggiano, 2011; Interprofessional Education Collaborative Expert Panel, 2011).

Alberta has declared a move toward team-based care (Alberta Health and Wellness, 2010). Directed by the provincial government, encouraged by health organizations (World Health Organization, 2010), endorsed by professional regulatory bodies (for example: Canadian Nurses Association, 2011) and sanctioned by the academy (Greiner & Knebel, 2003), team-based models of care require healthcare professionals to develop competencies that ensure effectiveness. Over the past decade, exponential growth has occurred in researching interprofessional topics, including team functions and processes and particularly the education necessary for these processes (Reeves et al., 2010).

In the president's address of the Association of American Medical Colleges, Dr. Darrell Kirch detailed the cultural change necessary within medical education to realize

interprofessionality from one “focused on autonomy, competition and individual achievement to one that valued collaboration, shared accountability, and team performance” (Kirch, 2007, p.10). Similar calls have been made in other health sciences disciplines (Canadian Interprofessional Health Collaborative, 2010). While organizational aspects of teams are well understood, literature on the relational aspects of healthcare professionals working together is noticeably scarce.

Communication is seen as an obvious relational dimension of healthcare teams, with other attributes undergirding team effectiveness (Weaver, Salas, & King, 2011). Teamwork behaviour such as coordinating activities, cooperating and sharing information is linked to effectiveness (Sheng, Tian, & Chen, 2010, 2010), yet can exist without explicit attention to the emotive and reflective elements. Relational features of healthcare teams include the ways in which practitioners behave interpersonally and interact to manage the intersections of their practices (Parker, 2002) in coming together to achieve mutually developed health goals about care.

Although health sciences curricula focus on teaching students that patient-centred care is foundational in healthcare, identifying how patients factor into the constitution of a team and explicitly describing the patient’s role on the team can be vague (Orchard, 2010). Questions arise about how a team is defined and by whom (Barrett, Curran, Glynn, & Godwin, 2007). This may be where the *we* becomes part of the healthcare conversation.

Collaborative care is differentiated from models of care that manage or co-ordinate health activities, sometimes referred to as *co-ordinated care*. Co-ordinated care is individual-professional or uni-professional care provided by several practitioners independently, often by referral and is disjointed on the point of common planning of care. An example is a primary care clinic that makes referrals for patients to obtain access to allied health providers. Often the communication between care providers is by letter or email creating a triangle with the patient at

the apex getting information from each healthcare provider, the two providers sharing some of information, but the two practitioners remain disjointed in developing care goals.

Collaboration[6] requires deliberate involvement at all points of care, from prevention and assessment to interventions and maintenance of health. Collaborating with individuals from varied health sciences backgrounds requires intentional structures and attitudes. Most current practices are carried out in isolation or in a multi-disciplinary model where each independent practitioner assesses, advises, and treats a patient in a consultative way, rather than collaborating on approaches to planning and implementing care decisions. Collaborative patient-centred practice shifts from independent to shared care planning in a team approach to care (Orchard, 2010). The team's composition has an effect on how the relationships develop among team members and how their interactions ultimately influence health outcomes. These interactions, creating planes, angles and shapes, are demonstrated in team functioning, including the patient's presence and association with, or integration into the team.

Does using the word *we* make someone a team member? When the SLP said, "*We* have a major problem here" after Jas' session years ago, the implication was being part of a team, our team. The *we* was meant to be performative[7] yet only partially achieved it. *We* did have a problem, but *we* would approach the problem differently. Approaching challenges differently became more evident as my research unfolded and I began to see the influence of performativity.

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[6] The transitive verb *collaborate* means not only to work jointly, but to "co-operate traitorously with an enemy". In exploring healthcare team function, each definition may be exposed. Team assumptions about collaborative functions being present or desirable needs to be troubled. Co-operate, meaning to "work jointly towards the same end" does not necessarily include interprofessional process where the "work" is independently decided upon (Collaborate, cooperate, The Canadian Oxford Dictionary, 2004).

[7] Austin (1979) used the word *performative* to describe a word that operationalizes the utterance. While he states it to be a "rather ugly word and a new word" (p.235), he was satisfied that there was no other word that satisfactorily could be used. Others, such as Judith Butler and Eve Sedgwick have taken this work further. I situate this work along similar lines describing performativity as the citational iterability of healthcare team performances. For an in-depth discussion, see Chapter 4. Interestingly, this concept became more apparent in the work as it progressed. My dissertation reflects this development.

Performativity refers to an expressive action (Austin, 1962), usually associated with language, or not in the instance of silence. The healthcare provider utterance of *we* seemed to create a team. The references in my story about Jas describe my team-member position being performed as a mother where I chose to not speak. I chose a liminal place[8] where silence is accepted in a system expecting compliance, and yet can lead to further obstacles. No utterance by me, yet the silence was performative. When would w*e* a team? Does saying *we*, as a declaration, become performative and can it operationalize teamwork without processes?

Carrying out a role within a healthcare context, the vernacular *we* can be seen to infer companionship or solidarity in the situation without actually meaning it. Using a ritualistic *we* is an expression of restored behaviour that is "symbolic and reflective,"[9] (Schechner, 2002, p. 36) reinforcing meta-messages of authority in a healthcare system. When a healthcare provider performs an assumed role, it could be explained as *Me* behaving "'as I am told to do' or 'as I have learned'" (Schechner, 2002, p. 28). Nurses and other healthcare workers fulfill roles as colleagues, mentors, advocates, leaders, educators and experts. Each of these roles becomes a *Me* yet in one person. Schechner would call this an expression of multiple *Me*s in repeated performance. The performative aspect of healthcare teams can be seen as a cultural ritual, comprising language (jargon), masks (nametags, white coats, uniforms), and performances on cue that elicit conditioned responses (reinforced positions often including subservience).

Understanding roles, evaluating performance, having centre stage, playing a part, creating a scene, rehearsing, using props or being upstaged are not just theatrical metaphors. They are ways of relating in a team. Examining teamwork is often developed in organizational

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[8] Social drama theory developed by anthropologist Victor Turner describes liminality as a place of transition, *betwixt and between*, an extension of Van Gannep's initial usage to denote an intermediate ritual phase (Turner & Turner, 1985).

[9] Schechner (2002) suggests that behaviour stems from "material" of processes known and unknown over several "rehearsals" that are separate from the individual who is demonstrating the behavior, suggesting that when the behaviour is manifested it is the "second to the *n*th time" (p.36) and is therefore, restored.

management literature, an interest of the business sector and more recently, in shared writings of business and healthcare professionals to address the unique and complex features of healthcare delivery.

Merging organizational theory and healthcare services is becoming increasingly common as evidenced in recent books by Gittel (2009) and Christensen (Christensen, Grossman, & Hwang, 2009) addressing the subject from a business perspective. These works highlight confounding aspects of integrated care, yet fall short in providing an understanding of the boundaries, negotiations, regard or openness of people as they come together alongside health experiences.

In previous work, Gittell (2009) developed a theory of "relational coordination" based on studies of Southwest Airlines (Gittell, 2003) and suggests that work can be harmonized through relationships of shared goals, shared knowledge and mutual respect. Similarly, Gittell (2009) suggests that patient needs are met through complex work processes that have similarities to the airline industry. Contending that tasks need to be accomplished within relationships, Gittell argues that the relationships constructed are between *roles*, not between specific individuals, accommodating "interchangeability of employees" (p. 19). This is where the transferability ends; patients are central to being part of the team and hence not interchangeable.

Christensen is known for identifying business model innovations as "disruptive technology"[10] (Christensen et al., 2009). Relating the model of disruptive innovation to the healthcare business, Christensen suggests that the three types of business models (solution shops, value-adding processes, and network facilitators) each experience innovation as disruptions as either a change in the business model type, or as a disruption within the model.

[10] *Disruptive* means an innovation for making something simpler and more affordable, and *technology* is used to describe combining inputs (materials, components, information, labour, energy) to produce outputs of greater value.

Each disruption is composed of “three enabling building blocks: a technology, a business model and a disruptive value network” (Christensen et al., 2009, p. 37). Suggesting that current healthcare delivery, rooted in centuries-old systems of regulation, contracting, pricing and reimbursement systems based on “yesterday’s frontiers” of medicine (Christensen et al., 2009, p. 74), is trying to co-mingle solutions shops (diagnostics) and value-adding processes (fixing the problem that was diagnosed). This creates “extraordinary internal incoherence” (Christensen et al., 2009, p. 77) of resources and processes resulting in outcome values that cannot be measured. Using metrics such as length of stay or readmission rates as indicators of team effectiveness is at odds with aspects of relational team components that tell the story of the team and ultimately what is necessary to achieve team outcomes.

The system’s internal incoherence can be addressed through integration and specialization, creating a coherent solution shop or a value-adding process hospital. Christensen suggests that separating the two “makes it possible for the patient to be in the care of a true team” rather than separate departments of a general hospital where the “structure makes working together and coordinating care cumbersome” (p.83).

Aside from the inherent difficulties in interpreting a translation into the Canadian healthcare context, fundamental flaws and gaps appear in this business model approach to implementing interprofessional team care. Team interaction has implications other than measuring productivity or economic impact. It is about responding to the human element in the experiences of health and realizing how healthcare decisions are made where the patient is viewed as part of the team. It is identifying and naming the dimensions of healthcare teams that establishes an environment to *know* and create healthcare texts together.

How are Healthcare Texts Performed?

Team dynamics is an extensively researched concept within business and organizational management[11] (Oandasan, Baker, Barker, Bosco, D'Amour, Jones, et al., 2006; Sheng, C., Tian, Y. & Chen, M. 2010). However, the relational aspects of teams are not well understood in general, and even less so in healthcare environments (Lerner, Magrane, & Friedman, 2009), particularly where a patient's role within the collaborative team is taken into consideration (Orchard, King, Khalili, & Bezzina, 2012). The tendency to consider business conceptualizations of teamwork for direction in healthcare team development overlooks the organically formed teams that address patient needs without recognition or credit and did so prior to the interprofessional movement. These like-minded professionals responding to their own assessments could potentially have structures imposed that may or may not be helpful in attaining their goal in care. Additionally, a debate rages as to whether healthcare *should* be a business or if it is entrenched as a societal value in Canada making it a service of citizenry, or perhaps a civil right.

Recommendations for healthcare delivered in team structures was initially proposed to address patient safety concerns (Kohn, Corrigan, & Donaldson, 2000; Weaver et al., 2011). Much of what is known about teamwork is informed through organizational management, and needs examination as to the applicability to healthcare teams. Purposefully identifying what knowledge is transferrable, differentiating what uniquely applies to the healthcare environment, and generating new understanding about what works in creating and maintaining effective healthcare teams is an urgent need.

[11] This trend may be changing. While it has significant implications in how healthcare teams view teamwork, a keyword search "team* (truncated)" with subheading "patient care teams" in Medline limited to publication year in 2005 yielded 1656 articles, yet the same search in 2011 yielded 2225 entries. There are tensions in reconciling the health business demands with human experience on several fronts including resource allocation, ethics, access, and value-added decisions.

The concepts of team culture, teamwork behaviours, personality, interpretations of collaboration, and other factors of team performance fail to explicitly name and describe the nature of personal interactions on healthcare teams. These contribute to the way that team members establish boundaries, create identities, negotiate power and delineate expectations of each other in a healthcare context.

The term *relational work* needs clarification. The phrase *relational work* sometimes describes an occupation in traditional caring-involved areas of employment such as social work, teaching or nursing (Ramvi & Davies, 2010). It also broadly describes the effort, knowledge and behaviours (work) necessary for effective interpersonal relationships to be formed and maintained (Hovey & Craig, 2011; Wright & Brajtman, 2011). As well, it can describe the interactions between professionals whose care-giving roles intersect or are interdependent (Gaboury, Lapierre, Boon, & Moher, 2011; Oandasan et al., 2006). *Relational work* in this dissertation is defined as the interpersonal aspects related to developing and maintaining a collaborative professional relationship. These aspects include the beliefs, attitudes, perceptions and values of each partner in the relationship that motivate behaviours to accomplish team tasks and purposes.

Beliefs and values about how team members fit within the team are foundational to team relational behaviours. Perspectives and decided positions about gender, stereotypes of other professions, hierarchies, ethnicity, power distribution, identities and socially constructed roles will affect team dynamics. As a group of tasked individuals evolves into a team, negotiated boundaries define the borders, as well as the permeability of those borders, and shape territories of the shared spaces or border-lands. Tensions surface as discussions about authority, leadership, accountability and vision scaffold the structure (D'Amour & Oandasan, 2005). Competency in specific interprofessional functioning may be inadequate, particularly when the team's composition is imposed.

Currently, it is the usual case that healthcare teams exist within the functioning hierarchy of the system. With IP, hierarchical structures are contested with democratizing[12] approaches (Bleakley, Bligh & Browne, 2011). Bleakley suggests that medical education may be at a tipping point which could see the dominant flow of power displaced, shaping a new medical identity. The vertical-to-horizontal shift moves from autocratic hierarchies through meritocracies to participative, monitory democracies[13]. The tensions that arise in such ideological shifts become manifested in socially constructed roles in the way in which they are performed within the context of a healthcare team.

Healthcare Teams and Relational Work

The concept of teamwork seems ubiquitous. Teams are found in several fields such as sales, teaching, projects, games, and of course, athletics. Actually, sports teams seem to be the common metaphor used when discussing teamwork. While this may bring a sense of familiarity to the subject of teams, it may also suggests that those in healthcare teams carry with them preceding ideas and expectations about teamwork into their professional practice.

In a recent search of a large online Canadian bookseller, more than a thousand book titles were identified with the keywords *team* or *teamwork*. When *health*, *health care* or *healthcare* were added to the search, the numbers dwindled to fifty, of which several were out of print or unavailable. Only ten were current and few of those were on the shelves in the stores.

[12] Bleakley (Bleakley et al., 2011) discusses the influence of hierarchy in healthcare by differentiating power structures suggesting that the shift from paternalistic sovereign power to a Foucault inspired "capillary power" awareness meshes with the principles of democracy; the levels of democracy are assembly, representative and monitory (Keane, 2009). Meaningful contexts for participation (i.e. health sciences education) are forms of assembly democracy, with monitory democracy manifested in quality assurance and research as well as rigorous theory development (Bleakley et al., 2011).

[13] John Keane crafted the term "monitory democracy" to describe a post-representation democracy that inherently encompasses multiple power-monitory and power-contesting mechanisms (Keane, 2008).

The academic literature has a similar pattern, although much more has been written about healthcare teams and interprofessional teams in the past decade. According to the World Health Organization (2010), there is sufficient evidence that team-based healthcare has enough positive economic benefits to warrant action. Healthcare spending accounts for 8.6% of Alberta's GDP or $4,528 per capita in 2011, and is one of the highest rates in Canada (Canadian Institute for Health Information, 2011). It is logical that effective interprofessional teams would make fiscal sense and yet few books and articles are in circulation that explore and explain relationships and processes of healthcare teams. Suchman, Sluyter and Williamson (2011) suggest that much of current management threads back to Frederick Taylor's 1911 theory of Scientific Management where workers are akin to pieces of machinery. They propose that the healthcare environment today has a better alignment with complexity theory.[14]

In exploring how healthcare teams fail to work together, Gittell (2009) suggests that high-quality connections between people are a basic requirement to coordinating the activities necessary for teamwork. This model in health delivery seems to be gaining momentum in the United States (Suchman, 2012). Suchman challenges the medical community specifically, and healthcare providers and administrators generally, to acknowledge the foundational influence relationships have in delivering healthcare in a system saturated with complexity (Suchman et al., 2011).

Suchman's (2012) understanding is a welcome bridge between organizational theory and complexity theory in conceptualizing the dynamics of healthcare teams. Yet it falls short in a conversation about the necessity of first identifying and making explicit the human interactions

[14] Chaos theory, proposing that small differences in initial conditions have significant effect in making outcome predictions difficult, gave birth to complexity theory, which suggests that complicated and dynamic relationships of interacting agents are conditions that can create behaviour patterns. The complexity may be the result of multiple chaotic or non-linear interactions (Bentley & Maschner, 2007). These theories have roots in mathematics and computing science (Davis & Sumara, 2005). Others have developed the relationship between such theoretical positions and workplace learning (Fenwick, 2008) that can be further extended to healthcare.

that contribute to the behaviours of individuals in their roles on a team, and the social constructions that contribute to the status quo, or vice versa.

Hierarchal norms are being confronted as the complexities of modern healthcare demand cost containment and accountability in a universal system that spends more and more. One approach to addressing concerns of cost, with the added benefit of increased patient safety, is delivering healthcare in interprofessional teams (Barrett et al., 2007). The movement toward integrated care over the past decade has accentuated the tenuous social relations and positions of power within the healthcare community or, as the renowned ethnographer Turner (1977) might recognize it, a breach of social code of how the business of health operates.[15] The traditional holders of influence, specifically the medical community, have been challenged to work collaboratively with other care providers.

Interprofessional teams trouble the current power configurations, a consequence of a system change that takes all healthcare providers into new territory (Bleakley et al., 2011). Such is the current climate in primary care, an essential component of primary health care.[16] As opposed to specialist care, primary care is the first-line care an individual can seek in maintaining health and addressing variances in health (Primary Care Initiative, 2012).

Anecdotally, members on a few primary care teams have voiced their desire to have interprofessional education to help them increase their knowledge about teams as well as experiences to build team processes and capacity. Post-licensure IPE is sorely lacking. Failure to address this deficit risks the possibility that newly graduated professionals who have been trained in interprofessionalism will only see it as a theoretical construct (Delva, Jamieson, &

[15] Victor Turner's Social Drama Theory, influenced by Goffman, analyses social situations and rituals in terms of "breaches" with specific movements of transition as a post-modern dramaturgy (Turner, 1987). Goffman introduced a performance-oriented theory using metaphorical theatrical language in explaining everyday life (Goffman, 1959).

[16] Primary care is also referred to as *primary health care* in some jurisdictions but the distinction should be noted that this type of usage is differentiated from the WHO definition that contains population health dimensions. Primary health care principles include primary care (Romanow, 2002).

Lemieux, 2008) rather than as a way to ensure health for all, the ultimate goal of primary health care.

Ongoing IPE is one of several gaps that exist in realizing the goal of effective teams (Xyrichis & Lowton, 2008). These gaps point to the need for research to clarify the processes and specifically the relational work necessary for healthcare teams to be functional in practice.

In my next chapter, I turn to the methodology and methods of my research that furthered questions that were raised about interprofessional teams. As in this chapter, reviewed literature is threaded throughout the discussion.

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Chapter 2: Methodology and Methods

Discovering Roles and Relationships at Play in Healthcare Teams

What healthcare providers *do*, their performance, ultimately becomes fused with their internal identity and the exterior message to others (Gittell, 2009). Schechner's (1985) views of performance may suggest that the identity concept of '*me' the professional* is a restored behaviour in the projection of *what a professional does*.

Concepts of performance and arts-based research methodology.

Creating knowledge with healthcare practitioners about the relational aspects of their team processes involves methodology that invites meaning-making. Participants in this study came from varied healthcare teams motivated to tell their stories to expand understandings and co-create knowledge about being a team. Arts-based methodology provides the philosophical underpinnings of the approach to answering my research question. Research that is located in the arts uses artistic expression as the prime approach to collecting, analysing, interpreting and explaining data[17] (McNiff, 2008). It is a systematic inquiry approach that, by design, evokes an emotional response to new knowledge. When it is grounded in critical performance pedagogy, performance "opens contested spaces and liminal sites" for dialogue (Finley, 2008 p. 79). Arts-based research encompasses an epistemological path of aesthetic knowing that is well-suited to explore the interpersonal activities and processes that occur in healthcare teams.[18]

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[17] One phase of a research process is usually referred to as "data generation". I trouble the word *data* and its use in aesthetic inquiry such as this research. *Data* implies an objectified piece of information whereas arts-based research aims to experience embodied understandings to inform exchanged understandings and analysis among participants and the researcher(s).

[18] Barone and Eisner (2012) clearly link aesthetic knowing to interpersonal activities and processes in education. This link is new in the healthcare world. The etymology of the word "aesthetics" is linked to perception and senses

Arts-based research as defined by Barone and Eisner (2012) is research where aesthetic qualities permeate the inquiry. The knowledge created with an aesthetic axis can be particularly useful in interpreting interprofessional "texts," as it highlights sensitivities and perceptions. Revisiting their earlier classical position, Lincoln, Lynham and Guba (2011) acknowledge that epistemological, ontological, methodological and axiological considerations were unmet in previously acknowledged paradigms that had been considered foundational in the world of aesthetic inquiry. [19] Now, a new paradigm suggests that performance has ethics and aesthetics embedded *within*, not external to, the paradigms. Considering a participatory or cooperative approach to exploring the known, Heron and Reason (1997) delineate four interdependent ways of knowing (experiential, presentational, propositional and practical) in response to Guba and Lincoln's well-known questions (ontological, epistemological, and methodological) with practical knowledge being privileged. Practical knowing ties together the other types of knowledge (referred to as "knowledges" later in this paper) and brings them together in action (Reason, 1998).

Co-creating knowledge with participants through an arts-based methodology provokes tensions in academia where the written text is privileged over other representations of knowledges (Denzin, 2003). Conquergood (1998), asks the questions, "What is at stake in the desire to blur the edges, dissolve the boundary, dismantle the opposition, and close the space

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(Aesthetic, 2012). Both are key processes in understanding the relational aspects of healthcare teams. Thus, exploration of team interactions using the senses for embodied understandings may contribute to increased perceptiveness.

[19] By including this aspect of inquiry, Lincoln et al. concede that over time they changed their minds about a *participatory paradigm* demonstrating what Geertz rightly predicted as a "blurring of genres"(Geertz, 1980). Heron and Reason (1997) suggest that the subject-object connectedness precedes representation and language allowing consideration that experiential knowing is a form of "radical empiricism" (p. 276). They also contend that the term empiricism has been reclaimed from "positivist abuse" through acknowledging an experiential, participatory research paradigm. Lincoln et al. (2011) acknowledged the gap in describing research paradigms. Their revised seminal work now identifies where and how the paradigms come together, are different, remain controversial, and where contradictions needed to be addressed.

between text and performance?" (p. 25). He further wonders about what gets lost in "reworking of performativity as citationality?" (Butler, 1993 p. 14).

In addressing his own questions, Conquergood (1998) recognizes the timing aspect of the current research conditions in a good news/bad news sort of way. The good news is that notwithstanding continued anti-theatrical prejudice, performance is now a "rallying point" (p. 25) for scholars who want to "privilege action, agency and transformation." Challenging the "scriptocentric" western academy, Conquergood suggests that epistemological pluralism unsettles "valorized paradigms" as it expands understanding through performance-sensitive ways of knowing. The bad news is that text remains supreme, held in higher esteem than generated knowledge from direct experience as in performance (p. 25). This study is an attempt to trouble the primacy of representations over experiential knowing in healthcare research.

Goffman (1959) brought mimesis to inquiry in the social sciences by explaining front/back stage boundaries and the idea of frames in seeing the performative side of everyday lives (Goffman, 2004). Goffman's (1959) iconic sociological analysis of the dramaturgy of life involves seeing day-to-day human interactions not only in a metaphorical sense of drama, it invites further inquiry of social interaction through examining the usual performances of people. In analysing daily life, Goffman introduced the notion that human interactions are actually social performances. Such ideas moved the concept of *performance* from scripts and physical theatres (where mimesis is key) to the everyday way in which we act, what we each *make* of ourselves (poesis).

A shift has occurred that emphasizes process over product (Lewin & Reeves, 2011). In detailing the "semantic genealogy" of performance from mimesis to poesis (largely due to Turner's (1969) social drama theory, Austin's (1962) identification of performativity and Schechner's (1985, 1988) concept of restored behaviour, Conquergood (1998) demonstrates a

full turn to kinesis, where performance communicates – moves – beyond its "referential content," (p. 32) breaks and remakes meanings and traditions and in turn, forces politics.[20] Appreciating the shift as Conquergood describes it, challenges hegemonic notions of evidence that are held in healthcare arenas. By utilizing alternative structures of creating knowledge through performance, other forms of evidence generated through lesser known methodologies can be embraced.

Exploring healthcare teams through theatre offers an ontological perspective of the "glue" that holds the team together. Health science research can be considered in light of the broader context of social science study such as in participatory or post-modern paradigms. This participatory way of engaging in research is in contrast to paradigmatic positions that delineate and organize perspectives.

Ontologically, co-created subject-object realities are "known" by knowing *with* other knowers (Heron & Reason, 1997). In other words, understanding is not imposed; it grows organically from a shared experience. Inquiry in this way is a relational way of viewing the world with fellow humans and invites a participatory creation of knowledges. The current climate in healthcare research has shifted to now acknowledge participatory inquiry as a paradigmatic position. In examining the hierarchy that exists in healthcare, it is essential to use methodology that purposefully conveys participation as a component of the research design. Current healthcare research includes the co-creation of exploratory spaces alongside participants, opening up a new place to acknowledge another's experienced reality.

The timing of this freedom was set historically as an outflow from the "crises of

[20] In the referenced article, Conquergood (1998) concludes by conceding that the written text will remain in academia yet with the continued questioning of what gets "lost and muted" (p. 33).

representation"[21] where new-wave research locating the researcher as an observer in the world with a "naturalistic approach" (Denzin & Lincoln, 2011, p.3) were the researcher has an ethic of care in the relationship with participants (Finley, 2003). Inquiry methodology progressed through a poetic moment to a performative turn where, not only is aesthetic inquiry utilized to communicate research findings, but also to generate data. McNiff (2008) draws attention to Gadamer who sees all attempts at experiential knowing as being aesthetically oriented.

Approaches to inquiry through qualitative research have evolved over eight eras or as historical moments according to Denzin and Lincoln (2008). This, the eighth moment (from 2010 into the future), confronts the "methodological backlash associated with the evidence-based social movement" and is concerned with moral discourse and the "development of sacred textualities" (Denzin & Lincoln, 2011, p.3). It is a time for "critical conversations about democracy, race, gender, class, nation-states, freedom, and community" (Denzin & Lincoln, 2011, p.3).

Interprofessionalism confronts power by establishing democratic processes (Bleakely et al., 2011), disrupts traditional modes of operating and requires reflexivity. The WHO's Framework for Action on Interprofessional Education and Practice (World Health Organization, 2010) challenges stakeholders in health systems to "resolve to change the culture and attitudes of health workers" (p.7). A mechanism of change may be discovered using aesthetic components to uncover meanings and understandings. An example of how this congruence may play out is by utilizing applied theatre methods (Diamond, 2007) to explore

[21] Denzin and Lincoln (2008) identify the "crises of representation" era of qualitative research occurring mid-1980s to early 1990s. The crises refers to challenging the assumption that research of human subjects can represent those subjects in an authentic way (Sandelowski, 2006).

interprofessionalism[22].

Arts-based methodology embraces methods to collect and analyze data and then derive meanings to further understand phenomena. This research approach allowed for collecting data at multiple points and is particularly compatible with discovering performative dimensions of interprofessional teams.

Post-modern influences, philosophical dialogue and resurgence of arts and humanities in health science education offer opportunities for enlightenment within pedagogical and professional realms. Small progressive steps are required where resonance is realized in place of generalizability; authenticity and credibility rather than a standard of rigor is found in crafting art alongside knowledge. Inroads are being made with credible arts-based research and innovative ways of creating knowledge, requiring that particular attention be paid to the questions of validity and how this is handled consistent with the methodology (Lather, 1993).

In acknowledging the "inadequacies of positivist assumptions in the face of the complexities of human experience" (Lather, 1986, p. 63), Lather's classic reconceptualization of validity highlights the imperative of data trustworthiness in "alternate" paradigms of inquiry.[23] Multiple forms of validity are manifest in positivist designs (discriminant, construct, face, related reliability, etc.), placing the concept of subjectivity in opposition. Resisting objectification while instilling assurance in the findings challenges researchers who use aesthetic ways of engaging in research.

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[22] Applied theatre is used here as a broad term. Pendergast and Saxton (2009) define applied theatre as an umbrella term that embraces alternative theatre practices. In applied theatre performances are often generated and interpreted without a pre-written script. Denzin (2003) refers to performance's multiplicity of terms that can become somewhat cumbersome and might be used interchangeably creating confusion. Performance is described by Denzin (2003) as an "act of intervention, a form of criticism, a way of revealing agency" (p. 9).

[23] Lather remains unchallenged in exploring the concepts of validity in arts-based research and continues a "seeming obsession with the topic of validity" in promoting "generative methodology" that moves toward "science with more to answer" considering world complexities (Lather, 1993).

The epistemological and methodological questions of confidence and trustworthiness are relevant in the paradigmatic messiness of arts-based research. Lather offers four crucial checkpoints for *self-reflexive human science*. These checkpoints, which offer protection to the researcher, are: a) triangulation, including utilizing multiple methods, data sources and theoretical schemes with research designs that seek out convergences and counter-patterns in the data; b) construct validity that utilizes systematized reflexivity that challenges a priori theoretical positions; c) face validity through member checks; and d) catalytic validity in enacting Freire-inspired conscientization which has a transformative influence on reality by *knowing* reality.

Lather's hope is that a more equitable world will be the result as rigor is explored alongside relevance of social knowledge. McNiff (2008) emphasizes the need to be clear in describing the methods of arts-based research and extends the research question not only to the fit of the method, but to the creation of the inquiry process. The methods of applied theatre that I used in this research align with a participatory paradigm and demonstrated the co-creation of knowledge through aesthetic experiences consistent with arts-based methodology. Coherent with the checkpoints suggested by Lather, I sought out convergences and patterns found in multiple methods of generating data (conversations, workshops, forum theatre interventions). I ensured intentional reflexivity in field notes, interview questions and on-going iterative analysis, elicited an exchange of understandings and analysis between healthcare teams and team members, as well as explored with participants ways to make plain a transformative awareness of what was true to their own reality.

Performance methods of inquiry.

Through methods in performance, participants explored relational aspects of healthcare teams to co-create knowledge and meaning of team interactions, functions and processes.

Participant's experiences of being in a team were analysed alongside participants to explore the relational dimensions of teamwork.

Bergum and Godkin (2008) suggest that nursing research and the transformative value of art brings new knowledge and insight when space is opened between the researcher, art and the public. It becomes a significant space where "something new is possible – where disruption occurs and the new begins" (p. 604). They describe this transformation as being one of "fleeting experiences" becoming stable and lasting coherently created forms (p. 604).

Traditional theatre can be used as a knowledge translation strategy. Bergum used theatre to disseminate findings of her phenomenological research of teen mothers: the play *A Child on Her Mind: A Play*, was the result (Bergum & Godkin, 2008). Other examples include communicating focus group findings of the experience of traumatic brain injury (Rossiter et al., 2008) and a representation of findings exploring elderly persons with Alzheimer's disease (Kontos & Naglie, 2007). Kontos has developed a model of knowledge translation specifically targeting drama as an effective strategy (Kontos & Poland, 2009).

Theatre can also provide a way to generate knowledge. In this study, theatre created an opportunity to explore root explanations of relationships in interprofessional teams by making explicit social constructions of power in healthcare, hierarchies, the role and scope of practice matters, and other unique aspects of healthcare professional interactions. The mechanism to create this knowledge came out of an applied theatre technique called *forum theatre*, a sub-type of the genre known as Theatre of the Oppressed (TO) (Boal, 1985).

Applied theatre is an overt attempt to reveal and disturb socio-political norms in relationship to the actual workings of the world (Pendergast & Saxton, 2009)[24]. Through

[24] This prepares the ground for the development of interdisciplinary health theory that encompasses nursing's "situational" position in interprofessionalism. Current nursing theory development that is relevant to the practice environment is needed (Meleis, 2012). Interprofessionalism raises tensions within uni-professional groups about

theatrical representation of the workings, tensions, system factors, emotions, hegemonic forces, power differentials and socially constructed roles, an aesthetic experience brings insight and knowledge about team members' lives in the increasingly interprofessional world of healthcare. Theatre opens a space to explore these dimensions of practitioner realities and interactions.

TO is a theatrical movement with its roots imbedded in the political theorizing of Freire's work in Brazil (Freire, 1979/2011). The movement, developed by a fellow Brazilian Augusto Boal in the 1960s, is currently seen as a source of community political expression accomplished through theatrically and playfully exploring pressing matters with interested community members (Pendergast & Saxton, 2009). Boal refers to TO as "the *Game of Dialogue*: we play and learn together" (Boal, 2004a, para. 1) in assisting communities to take action on an agreed-upon issue (Boal, 1985). The "oppressed" describes anyone who has "lost the right to express his/her wills and needs and is reduced to the condition of obedient listener of a monologue" (Boal, 2004b, para. 1). Boal contends that the usefulness of this approach to examine complex issues is not as a mirror, but as an "instrument of concrete social transformation" (Boal, 2004b para. 1).

Bringing participants together in this research served as an enacted focus group to explore the specific topic of being a team. The group engaged in theatre games and actions to identify and analyse ideas and concepts related to the topic. Through a process of iterative analysis and refinement, a series of collective stories created scenes that identified points of conflict and struggle. When the refined scenes were ready for performance, they were staged for audience member participants. In forum theatre, the audience is invited to break through the "fourth wall" of the theatre as "spect-actors" to intervene by engaging in the struggles to avert the crisis in the play. The intervention occurs by having the spect-actor replace the current

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maintaining uniqueness and identity. Orchard refers to this as "persistent isolationist" attitudes in nursing (Orchard, 2010).

actor, assume the character and change a scene while staying “in character.” Staying in character in this case means behaving and speaking in a way consistent with the way that the character has been portrayed throughout the play. The on-stage actors adjust the script using improvisation to respond to the intervention. The reconstructed scene reflects a further truth, expanded understanding, or some changed outcome by having characters take a different approach or perspective.

Canadian theatre artists have developed variations of TO methods. Headlines Theatre in Vancouver has expanded Boal’s framework in *Theatre for Living*, which retains much of the TO’s community-struggle aspect but adjusts more characters and scene outcomes, as spect-actors become involved with characters in addition to the protagonist. TO’s purpose is to not only explore the experiences of the oppressed, but the oppressor as well (Diamond, 2007). Other adaptations, such as Toronto’s Playback Theatre, utilize improvisation to interactively transform personal stories and narratives of the actors and audience into a scene (Playback Theatre, 2012). Diamond’s approach to dramaturgical dialoguing was used to engage Aboriginal youth to co-create knowledge and challenge habitual thinking of being “passive consumers of knowledge” that came to them from others, further reinforcing colonization. Forum theatre became a performance-based vehicle to create “imaginative blue-prints for possible healthy futures,” fuelled by the community’s analysis of real-life experiences (Goulet, Linds, Episkenew & Schmidt, 2011, p.96).

Using forum theatre is particularly suited to exploring some of the difficult and foundational realities that are at play in healthcare team relationships. Participants used the theatre experience to challenge their own words, interpretations, viewpoints, and ideas about self and others involved in their teams.

The pragmatics of method

Recruitment.

Recruiting participants involved inviting individual practitioners who were currently members of an existing healthcare team to join in this research. Using the guiding principles of community engagement (Lincoln et al., 2011) and the influences of appreciative inquiry (Dematteo & Reeves, 2011; Richer, Ritchie, & Marchionni, 2010), members of various healthcare teams were invited to participate in this study.

Individuals from several settings including acute care, rehabilitation sites and existing Primary Care Networks in the Edmonton, AB area were invited to participate. Potential participants were informed of the project through handbills and posters, word of mouth, personal emails and phone calls, and a *humanities in health* interest group. Individuals from varied disciplines and professions practicing in existing healthcare teams were purposefully invited to participate in this research project. Practice sites in healthcare with current interprofessional team structures in primary care, rehabilitation or active treatment were of particular interest.

Purposeful recruitment of diverse health professions was desirable to provide varied and relevant perspectives about authentic healthcare teams. There was little response from practitioners in primary care, an interesting situation given that the move toward team-based approaches to care is widely visible in primary care settings. Most responses came from clinicians in rehabilitation and acute care. I fielded calls and emails of persons wanting more information about the project. About 40 individuals expressed interest in participating with 8 contributing through interviews and 7 engaging in the full-day theatre workshop. The eight participants included: nurses, a physical therapist, medical researcher, nurse practitioner, alternative medicine practitioner, physician and an occupational therapist. Interviews provided a foundation for structuring the theatre activities.

The participants were not known to me or to each other. During the theatre exercises, the theatre facilitator and I worked with the group of participants, engaging with them in the activities and discussions. The theatre facilitator would further probe concepts of team work and interprofessionalism as they were brought up by the participants to describe aspects of their struggles. As part of the forum theatre processes, we explored together their experiences through iterative analysis. In the final production, all participants not on stage for a scene joined as audience members. One participant came forward to be an audience member only.

Data collection

Data was collected from multiple sources in two distinct phases. All data collection throughout the study occurred alongside a trained theatre facilitator (also called a *Joker)* in fieldwork.[25] Data emerged in phases through observations, conversations, training and dialogue as a dis-contiguous workshop with team members prior to a one day workshop. The Joker is an integral part of the study design as the theatrical link to produce respectable art and a quality theatre experience.[26] The first phase prepared the participants for the workshop through the exchange of ideas and perceptions of team members through interviews. These conversations provided scaffolding of the concepts, readying participants for the ritual space of the theatre for deeper, interactive exploration. The second phase of data collection comprised the theatre workshop day that culminated in creating a forum theatre play. Further data includes the videotaped record of the workshop activities, the play itself, interventions from the audience (i.e., the spect-actors), transcriptions of the play, and post-production conversations with the Joker which were recorded and transcribed.

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[25] The expert facilitator, Lindsay Ruth Hunt participated in interviews and analysis as well as directing the theatre experience.

[26] Lilja (2012) suggests that "(t)he research cannot be separated from the artistic practice. The artist is both the subject and object, for and within the research". Having a genuine theatre artist involved in this project as facilitator embraces a collaborative approach to aesthetic inquiry.

Phase One

Participants (n=8) were engaged in conversational interviews that were approximately one hour long and structured by guiding questions. The conversations were audio-recorded and transcribed. The data was reviewed by me and the theatre expert to determine common issues and themes to identify specific considerations for structuring the workshop.

Phase Two

Individual participants (n=7) attended a one-day intensive workshop and forum theatre production session. Data from this phase included photographs, video recordings[27] and field notes. The iterative process of shared stories, brought out experiences that resonated with the participants and highlighted aspects of interprofessionalism that were portrayed on stage. The development of this shared story told through composite characters was documented in field notes.

The production of a theatre play provided multiple data sets including the texts on the stage, and the texts off the stage. Spect-actor texts, Joker notes and dialogue with participants were all data sources. Audience interventions along with the evolution of the story on stage was captured in field notes and recorded on video. The video recording was transcribed to assist in further analysis. Following the workshop and play, I met with the theatre facilitator for a recorded debriefing session where we discussed the emotions and tensions that arose during the process of workshop, the iterative analysis that occurred in producing the play and the audience interventions.

Data Analysis

Data analysis occurred at distinct points in the process of preparing for the forum theatre, iteratively during the workshop with the participants, and while reviewing the video and transcripts of the theatre experience. Although a comprehensive discourse analysis was not

[27] The video recording of the play was done by a contracted videographer.

undertaken, some of the principles guided the interpretation of participant texts such as appreciating power relations as being discursive, a historical component of healthcare social interactions and discourse as a form of social action (Van Dijk, 2003) that aligns with the tenets of forum theatre. Critical discourse analysis is considered by some to be the most prominent approach to analyzing discursive texts where culture and discourse are fundamental to understanding multiple central concepts (Renkema, 2004). Within this approach, Koller (2012) suggests that collective identity is a "mental model" with cognitive and affective components that change through negotiation in discourse. Analysing the notion of collective identities in healthcare requires a framework that envelops the complexity of discourse within the representations and social constructions of the team.[28]

Data production and analysis were concurrent and ongoing throughout the workshop day. As concepts became apparent, conversations explored deeper understanding of concepts that contributed to the development of composite characters and merged events that became the play. Generated ideas and interpretations were part of an iterative and reflective process as conversations evolved and participants developed characters and events that resonated with their experiences in interprofessional teams. Analytical interpretations of discourse involved careful consideration of the link between discourses and issues of power (Mumby, 2004). The ideas and perspectives of participants were shared and explored to shed light on consistently-appearing topics or issues expressed by each of participants.

The theatre experience created fictionalised scenes as developed by the participants from their collaborative analysis to produce a collective story. Fictionalizing true situations allows for anonymity while maintaining verisimilitude in transforming and analysing data. These

[28] My interpretations are influenced through readings and coursework identifying critical discourse analysis as an approach to understand the observed and experienced discourses contextualized historically and socially as situated in the realities of healthcare. The influence of CDA draws on theoretical approaches of Bourdieu, Derrida, Lyotard and Foucault (Grant, Hardy, Oswick, & Putnam, 2004). Several other principles of CDA might also be considered in a full analysis.

"performative texts" brought together processes of "academic interpretation and representation" into proximity with authentic "performative events" in the lives of the participants (Conrad, 2004, p.16). The result was a co-created theatre piece.

The play that ultimately became staged was a culmination of the analysis that was co-constructed by the participants, researcher and Joker. Consistent with the tradition of TO techniques (Pendergast & Saxton, 2009), the facilitating Joker invited the audience to intervene and make adjustments to scenes in an effort to either support the status quo or seek change.

The nature of forum theatre intertwines conversations about the scripted observations, similar to debriefing them, with enacted responses to the analyzed data. New knowledge was co-created with team members by documenting and making explicit practices, language, structures, and gestures that exist in the interprofessional team. As co-creators of the knowledge, participants had the opportunity to express their insights, findings and the intended use of this knowledge of their shared experiences. Intentional reflectiveness to consider biases and challenge interpretations was integral to the process.

One analysis is described in the manuscript contained in Chapter 5. This analysis uses Pickering's (1995) theory of the Mangle of Practice to examine the influences of human and non-human agency in interprofessional teams. Some of the mangle "strands" that are found in interprofessional practices are identified through the conversations of participants and the script of the play created in this study.

Future analysis is possible by examining and further analysing the conversational interviews of participants that framed the forum theatre workshop. This data is rich in descriptions and concepts that contribute to or detract from interprofessionalism and teamwork.

Ethical Considerations

Individuals involved in group experiences are vulnerable, particularly where performance may expose a representational voice (Conquergood, 2003). In designing the project, I

considered the guidelines contained in the Tri-Council Policy Statement regarding ethical research (Canadian Institutes of Health Research, December 2010). This study was reviewed and approved by the University of Alberta Research Ethics Board.

It was impossible to ensure participant anonymity because of interactive group interactions, as participants got to know each other during the activities of the study including the workshops and performance. Participants were informed of their right to withdraw consent at any time during the study. I explained to the participants that involvement in a group, and particularly in performance, implies that anonymity is not possible during the theatre experience. However, all recordings have been kept from public view and all research assistants and video personnel have signed confidentiality agreements. Transcripts have been rendered anonymous and photographs depicting the staged scenes used in manuscripts have been re-enacted to protect the identity of the participants.

Consistent with community-involved research carried out in a participatory way, the relationships that form with participant teams may continue beyond the project time-line. Ongoing interaction is being maintained as desired between the participants and the researcher for continued understanding, verifying, and sharing of findings.

The methodology of this work requires sensitivity to the possible vulnerabilities of participants. Participatory methods, and specifically forum theatre, can call forth an emotional experience; while it too holds the potential to be transformative. One of the research participants commented that she had been waiting years to express thoughts about her experiences. For some participants, playing an active part and also engaging in imaginary and creative works can be therapeutic. At the same time**,** the risk that participants may be uncomfortable or intimidated with the improvisational nature of forum theatre called me to attend closely to each participant and the processes of forum theatre. Focusing on participant knowledge, work practices and team experiences may be particularly challenging, as

such attention might expose difficult aspects of the participants own practices and work. Awareness of these possibilities required me and the theatre facilitator to be awake to potential ethical and emotional aspects of this work.

Enacting Inquiry

This project adds to further understanding of how specific team members manage interprofessional relationships. Performative phenomena have a bearing on team experiences that, through this study, were identified and named, offering tools, vocabulary and variables for further exploring the influences these phenomena have in negotiating relationships in healthcare teams and in working interprofessionally. Utilizing an inquiry method that made explicit aspects of performance, roles, usual discourses, and team culture offered an opportunity to glean insight into further team processes.

Generalizability is not the objective with this genre of research. Striving for credibility and authenticity is the methodological goal. Finding resonance with the characters and events in the forum theatre experience allows other healthcare practitioners to inform their own practice. Such resonance is not generalizability, but an awareness of commonness and credibility.

This inquiry brought to front stage some of the relational work that occurs in interprofessional healthcare teams. The Alberta healthcare reform discourse needs this clarity as it strives to serve patient interests, improve the health of citizens, and educate healthcare professionals to be successful in the complexities of care.

The findings of this study provide clear descriptions of aspects and interactions in being a team that can further conversations to contribute to forming and maintaining successful healthcare teams. This research sets the stage to engage a healthcare professional community caught in a system that is transitioning toward interprofessional team practices. The intentional increase of interprofessionalism requires collaboration, making explicit team functions and developing insight into the scripts and frames that shape a team. Exploring the attributes of

healthcare teams created knowledge that can shape continuing conversations in healthcare reform to shift performance measures in healthcare, and perhaps even offer dramatic change.

Papers 1, 2 and 3

In the following three chapters, published and submitted papers describe the need for nursing engagement in the interprofessional discourse (Paper 1), provide a discussion of performativity as phenomena and methodology (Paper 2), and summarize the findings of this study using Pickering's (1995) theory of the *Mangle of Practice* (Paper 3). The concluding chapter (Chapter 6) summarizes my personal reflections and views to future research in understanding and supporting interprofessional healthcare teams.

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Chapter 3: Paper 1

Articulating Nursing in an Interprofessional World

This paper, published in the journal *Nursing Education in Practice* in November, 2013 (NEP 13:519-23) details some of the practical and theoretical dimensions of nurses engaging in interprofessional practices and the call to be clear in articulating the nursing components of interprofessionalism.

Abstract

It is essential that nurses in practice clearly articulate their role in interprofessional clinical settings. Assumptions, stereotypes, power differentials and miscommunication can complicate the interaction of healthcare professionals when clarity does not exist about nurses' knowledge, skills and roles. Conflicting views among nurse scholars as to the nature of nursing knowledge and its relationship to practice complicate the task of nurses in explaining their performance and role to others in interprofessional environments. Interprofessionality is potentially misunderstood by nurse leaders, practitioners and educators, isolating nurses in an increasingly inter-disciplinary healthcare system. The theorization of contemporary nursing is explored through the views and perspectives of current nurse scholars. The ability to explain nursing knowledge, skills and roles to others in interprofessional interactions is a nursing competency, as well as an interprofessional one. Nurses, nurse leaders and nurse educators are challenged to engage in interprofessionalism so as to have an influence in the evolution of healthcare education and practice environments.

Articulating Nursing in an Interprofessional World

Nursing practice environments are progressively becoming more interprofessional (IP) which challenges nurses to examine and adjust to increasing complexity and interdependency

in healthcare (Jooste 2011). The ability to describe nursing care within inter-disciplinary practice environments may be an overlooked capability with which nurses struggle. For a nursing influence to shape the evolving interprofessional world of healthcare, nurses need to engage in that world and be prepared to articulate to others what nursing actually is and what it is not. This discussion paper arises from questions about how other healthcare team members understand nursing practice. In an interprofessional environment, it is crucial that nurses be explicit in clarifying their role.

The explanation of nursing has been the focus of scholars over the past half century. Nurses in practice build on the conceptualization of nursing as it is understood from their education. It is important that interprofessionalism factor into this conceptualization for nurses to identify their distinctiveness as nurses. While involved in the development of an interprofessional clinical learning unit, it became evident that one of the most significant and persistent barriers to interprofessional clinical education was the inability of nurses to explain nurse work in interprofessional team approaches to care. Nursing education curricula aim to balance the practice and science of nursing, yet students need strong models of practicing nurses to nurture an evolving sense of professional identity. Nursing education provides an awareness of what makes nursing unique, how the discipline underpins the practice, and the necessity of nursing research. This awareness needs to extend beyond classroom education into the practice environment.

Novice nurses cultivate a nursing identity by developing skills, increasing knowledge and nurturing attitudes that are valued in nursing. Although not necessarily visible, this identity groundwork becomes apparent when a nurse is required to be clear about nursing roles. interprofessional interactions place nurses in positions to “share the nursing perspective,” an uncomfortable conversation when the response is ambiguous. When asked to describe

nursing, a nurse's response that "nurses care for clients" unfairly excludes the contributions of other professionals involved in the care. A very specific response, such as "I assess post-stroke swallowing," may be too contextual. Articulating what makes nursing essential in interprofessional healthcare is complex and is a concern for nurses in practice, administrators and educators.

This discussion paper addresses the confusion in nursing about interprofessionalism, unclear messages about nursing within the discipline, historical influences on nursing identity and nursing considerations in interprofessional care (IPC) and education (IPE). The ability to communicate nursing knowledge and roles to others in interprofessional interactions is a nursing competency as well as an interprofessional one. Ensuring the development and maintenance of this competency requires intentional attentiveness in nurses, nurse leaders and nursing educators.

Interprofessionalism

Reforms in western healthcare have resulted in increased interprofessional delivery of care. The driving forces toward more collaborative models of care were initially economic, with few outcome-related considerations. Evidence now exists to suggest that interprofessional healthcare teams make economic sense by capitalizing on skill overlaps through collaborative care, which then decreases services duplication and related costs (World Health Organization [WHO] 2010). Additionally, IPC improves patient outcomes, promotes effective communication among healthcare providers, improves patient safety, and contributes to professional satisfaction (Allison 2007; Bainbridge et al. 2010; Canadian Interprofessional Health Collaborative [CIHC] 2010; D'Amour & Oandasan 2005; Dietrich et al. 2010). Adequate IPE,

the necessary groundwork for IPC, has a positive effect on professional practice and patient care (Reeves et al. 2010).

The trend toward IPC is disquieting for some. Uncertainty about interprofessional practice and what it means may prompt some nurses to voice concerns, such as a worry that integrated care could erode professional boundaries or diminish scopes of practice. Such misgivings suggest a need to further explore misunderstandings and biases about models of care, stereotypes, and attitudes toward change (Ateah et al. 2011). Orchard (2010) suggests that a uni-professional approach to nursing education results in gaps in nurses' ability to work interprofessionally. Contributing to this uncertainty may be the term *interprofessional* and what it means.

Multiple words describe healthcare collaboration. *Inter-disciplinary, multi-disciplinary, intra-disciplinary, trans-disciplinary, multi-professional*, and *interprofessional* seem to be used interchangeably (Goldman et al. 2009). Organizational management terminology, such as *collaborative teams,* may also describe interprofessional work, but meanings vary. McBride (2010) suggests, "it may be that *interdisciplinary collaboration* is the most bandied-about phrase used by health professionals without common understandings" (p.74). Each term is problematic at some point.

Discipline depicts a discrete body of knowledge or expertise, yet *inter-disciplinary* is also used within medicine to describe connections between sub-specialties, such as obstetrics and pediatrics, as well as referring to intersections of other distinct fields of healthcare practice. *Multi-disciplinary* describes independent decision-making by involved healthcare professionals operating in silos, interacting with others in a consultative mode. *Intra/trans* prefixes are attached with vague differentiation; *intra* usually implying cooperative practices within a

structured group and *trans* connoting blurred functional or internal boundaries. In the interprofessional field, the confusion caused by these multiple expressions is both conceptual and semantic (Goldman et al. 2009). While it is important to have clear language, it is crucial that the meaning of interprofessionalism does not get lost in the signifiers.

Interprofessionalism is inter-disciplinary in nature, and there is growing international consensus that the word *interprofessional*, without a hyphen, be used to describe the integrated work of healthcare (CIHC 2010; WHO 2010). Widespread use of this single term provides consistency in the literature and a working definition. IPE "occur[s] when two or more professions learn about, from, and with each other" to improve health outcomes (CAIPE: UK Center for Advancement of Interprofessional Education 2002). Orchard (2010, p.252) defines interprofessional collaborative practice as "involv[ing] a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to share decision-making around health and social issues." This definition encompasses patient participation, an important interprofessional consideration.

Collaborative IPC is more involved than concurrent independent practices or a consultative model. In reviewing the evidence, the World Health Organization (WHO 2010) endorses IPE and collaborative practices in healthcare as an approach to "mitigating the global health workforce crisis," as well as "working with patients, families, carers, and communities to deliver the highest quality of care" (p.7). The contributing authors, explaining that IPE is a necessary step in having a prepared and "*collaborative-ready* health workforce" (p. 13), summarize 50 years of inquiry by affirming that "there is sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice" (p. 7).

The WHO defines *professional* broadly (2010) and does not limit the term to regulated professions, but to all contributors in care provision. Thus, a healthcare provider's own beliefs, practices, values, and socialized characteristics (Arndt et al. 2009) are brought into the interprofessional arena and contribute to the care that is delivered and the patient experience. The intent to enhance health by sharing the health management of people and communities is foundational in IPC.

Bringing such educational diversity together successfully requires intentional structure and processes, such as attending to time, space, and interprofessional considerations (Seneviratne et al. 2009). Salhani and Coulter (2009), in addressing "power, interests, ideology, autonomy, domination, control and struggle, and their relation to each other" (p.1222), suggest that a paradox exists in interprofessionalism where exclusionary and inclusionary processes can occur simultaneously. In studying a Canadian mental health team, they found that nurses utilize different forms of power to address divisions of labour, to gain control of varied aspects of nursing work, and to expand their jurisdictional boundaries, demonstrating complexity in the power and political dynamics of the relational work in interprofessional practice.

Nursing and Interprofessional Competencies

In Canada, interprofessional competencies comprising knowledge, skills and attitudes are identified in the *National Framework for Interprofessional Competencies* (CIHC 2010). Six competency domains are described as ways of assessing interactions and functionality in interprofessional work: interprofessional communication, patient/client/family/community-centred care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution. It is important to underscore that *collaboration* is not necessarily privileged over other competencies. Collaboration is understood contextually. For example, nurses may

collaborate easily with other nurses but defer to accorded power holders in interprofessional decision-making. Potentially, IPE could address how nurses' strengths can be utilized more effectively when the power dynamics are addressed. Examining such approaches that better facilitate an integrated and collaborative workforce is supported by compelling rationale discussed in a recent American expert review report (Interprofessional Education Collaborative Expert Panel 2011).

The Lancet Commission report on transforming the education of health professionals particularly targets professional education in not keeping pace with the increased complexity in health. It identifies systemic problems stemming from "fragmented, outdated and static curricula that produce ill-equipped graduates" (Frenk, J. et al. 2010 p.1). The recommendations in the report include ensuring transformative learning that allows students to achieve core competencies for effective teamwork in a system that eliminates the "tribalism" or isolation that persists in uni-professional education in the course of health sciences professional training.

The realization of this vision requires an adjusted view of nursing education. Nurses recognize the need to identify their knowledge and skills in interprofessional work. In 2011, the Canadian Nurses Association (CNA) published a position statement which acknowledges that "(e)ach profession brings its own set of knowledge and skill – the result of education, training, and experience – to collaborative health services… Shared decision-making, creativity and innovation allow providers to learn *from* each other and enhance the effectiveness of their collaborative efforts" (CNA 2011, p.2, italics added). While this statement identifies one aspect of IPE - "from", the two other dimensions, "learn with" and "learn about" (CAIPE 2002) are missing, perpetuating a misunderstanding that common learning is equivalent to interprofessional learning.

The Canadian Registered Nurse Examination (CRNE), the national licensure exam, tests 28 nursing competencies in the area of professional practice (Canadian Nurses Association, 2010). The exam blueprint for the years 2010-2015 includes three competencies relating to interprofessional practice: RNs must be able to articulate the scope of nursing practice to others, collaborate and build partnerships with healthcare teams, and understand the roles and contributions of other healthcare team members. It is expected that nurses have the ability to communicate to other healthcare workers what nurses know and what nurses do. According to Litchfield and Jónsdóttir (2008), articulating the significance of nursing work is an "essential thread of contemporary healthcare provision" (p.79). Nursing curricula that integrate informative, formative and transformative learning are intentional in ensuring that interprofessional competency for nurses prepares them to describe their work.

Following licensure, nurses have an ethical obligation to cultivate and augment such competence. Enhanced skill in explaining nursing work is one component of interprofessionalism that would support nurses in fully participating in integrated healthcare.

Historical Influences

An examination of nursing history brings to light the very core of nursing practice. In the 19th century, Florence Nightingale described nursing knowledge as, "[e]very day sanitary knowledge, or the *knowledge of nursing*, or in other words, of *how to* put the constitution in such a state as that it will have no disease, or that it can recover from disease…" (Nightingale 1860, Preface, emphasis added). Although *Notes on Nursing* was not intended to teach "nurses how to nurse," Nightingale clearly describes a link between what nurses *know* and what nurses *do*. This bond is less obvious today, with divided opinions regarding gaps between theorized and practiced nursing (Allen 2004; Rafferty et al. 1996; Risjord 2010).

Nursing theory developed in North America throughout the second half of the 20th century. Nelson (2002, p.181) argues that the professionalizing discourse shifted from history to nursing theory, leading to an ahistorical nursing science. It seems that theorists influenced nurses' understanding of "who they are, what they do and why" through humanistic philosophies of caring. Nelson suggests this has an effect on how nursing identity is shaped. Distanced from its history, depictions of nursing became a product of *theory*, rather than a product achieved from the *doing* of nursing in practice. This is not a call to return to the first wave of nursing theorists, but is an invitation to question the notion of past theories dictating contemporary practice. Rather, theoretical schools of thought provide a process for building new theory (Meleis 2012). Historical knowledge from nursing science pioneers informs current frames of nursing identity and provides insight into the consequences of uncontested oppression and hegemonic forces.

Nursing scholars have drawn on various influences in American culture, science, feminism, and professionalization of nursing to construct conceptualizations of nursing. Medical advances and institutional changes influenced nursing practice over the decades and expanded nurse-led research programs that began testing nursing theories. All the while, practitioners were still *doing* nursing and were creating practical theories that were derived from their experiences, rather than being the consequence of applying formal nursing theories.

Sitzman and Eichelberger (2011) suggest that nurses today can intentionally look for theoretical underpinnings of practice, rather than distancing academic discussion from lived practice. A theory/practice gap remains a challenge for the discipline of nursing. If this gap ere narrowed, nurses, when asked by others in an interprofessional work environment, could confidently explicate the role of nursing and the underpinning theory.

Nursing theories have seen a shift from the application of theories into practice to the development of theories based on practice. The ontological question, "Isn't nursing what nurses *do,* based on what nurses *know*?" is not reductionistic, but a standpoint allowing the broader scope of the discipline to be reconciled with the usual, practical work that nurses do (Allen 2004). The description of contemporary nursing through situational-specific theories (Meleis 2012) may provide spaces for the development of interprofessional theory in aspects of patient-centred collaborative care.

Exploring contemporary nursing knowledge, Risjord (2010) sides with Meleis (2012) and suggests that theory development can bridge the relevancy gap. Meleis (2012) proposes that a post-nursing theory era needs to focus on the practical needs of nursing (Risjord 2010) in building healthcare theory. Risjord expands upon the idea that practice needs to be reoriented in building nursing knowledge. Nursing would be in a stronger position in interprofessional work if the discipline of nursing and the practice of nursing could be reconciled. If the call is to situate nursing theory in practice, this paper is one attempt to do so.

Dobratz (2010) calls for "shared and valued goals" to bring about a reconnection between theorists and practitioners (p.66). Nursing performance, conceptualized and influenced by performance theory (McKenzie 2001), ties together nursing knowledge and nursing actions which allows nurses to be clear in explaining what they do. In the context of performance theory, this reframing needs to include the link between nursing theorization and the work nurses do.

Nursing Considerations in Interprofessionalism

The nursing academy has only recently begun to accept that interprofessional knowledge is a core aspect of nursing knowledge. A current nursing-theory textbook includes a

chapter discussing “multidisciplinary theory,” a welcome first step in theorizing the everyday work of interprofessional practice, that in turn has influenced nursing theory (Johnson & Webber 2010). In this context, the term “multidisciplinary” refers to multiple individuals using discipline-specific theories in uni-professional care, which is not actually an interprofessional approach. Nevertheless, it is an acknowledgement of the need for new theory. Nursing that is theorized within IPC models needs to be grounded in interprofessionalism. The recognition that nursing theory and interprofessional theory coexist is a tacit acknowledgment that professional interaction is a crucial component of collaborative education and care.

The embrace of newly theorized interprofessionalism is exemplified in projects where nurses have been central to interprofessional clinical learning. In Sweden, nurse facilitators defined their role as team builders (Carlson et al. 2011), working with interprofessional student teams on a clinical training ward. Jacobsen et al. (2009) found that nursing students engaged in clinical learning on an interprofessional training unit in Denmark gained a broad view of their own profession and core nursing tasks. Hylin et al. (2007), in a follow-up study two years after students participated in an interprofessional clinical training ward, reported that nurse facilitators were fundamental in the supervision and training of students from all participating professions. Part of the interprofessional experience involved all students contributing to the nursing care of a patient which offered a greater understanding of the nurse’s role on a healthcare team.

In building a clinical learning unit in Canada, the research team noticed incremental change in nurses’ perception of their role during the course of the project (Sommerfeldt et al. 2011). The unit was created by a working group of patient-care team members using a participatory research approach. At the beginning of the project, it was common to hear nurses say that they already “*do* collaboration.” Although some collaborative skills were evident as nurses consulted with other professionals in planning their care, staff nurses acknowledged that

interprofessional work was different than uni-professional siloed work, yet they were unable to describe the differences. After receiving IPE from the research team, a common retort of healthcare team members shifted from a quick, “We already do that…” to “Now, we…”. Team members began to understand an IPC approach, differentiated from previous conceptualizations of collaboration, and could connect it with their performance.

According to Orchard (2010), nursing maintains some practices that interfere with the ability to become collaborative team members. Those practices include the use of unique nursing language and adherence to profession-specific ownership of patient assessment and histories. For example, taking a patient’s history, which was traditionally done uni-professionally, could become a shared aspect of care. Orchard suggests that patterned behaviour which relates to a service orientation and which “fit(s) with the industrial age of ‘assembly-line thinking’” is perpetuated in nursing and does not consider the patient (p. 252). Cooperative history taking could symbiotically bring depth to a patient’s health story, decrease interruptions to the patient and set the stage for integrated care decisions.

Uni-professional learning has a direct bearing on skills brought to interprofessional contexts. Social constructions of power differentials, hierarchies, and institutional structures need specific attention. This includes addressing the stereotyped perceptions about the roles of others in healthcare that leads to misinformation and miscommunicated expectations or, worse, purposeful control and manipulation. For example, Gordon (2005) recounts that nurses who were seen as knowledgeable and instructive by a new medical student were perceived to be less skilled and capable of only expressing opinions about their patients by the time the medical student became a resident. This is a demonstration of under-appreciating different knowledges and other ways of knowing.

Learning interprofessionalism occurs through IPE and cannot be delivered uni-professionally either pre- or post-licensure. Preparing nurses, educators, students and administrators for an interprofessional workplace requires purposeful curricular decisions within nursing education and focused personal and professional development in practice settings. Nurse administrators and educators must consider pragmatic and effective means to ensure IPE in the practice and academic environment. Both practicing nurses and students need to have a clear idea about how nursing work is performed, and how to articulate it in understandable language and actions to members of the healthcare team and to patients.

Weinberg (2006), a sociologist, suggests that nurses describe their work with patients in relational terms. As an illustration of this, a nurse's account of *developing a therapeutic relationship* actually represents multiple assessments and interventions. The description is easily misunderstood or devalued by administrators trying to control costs. References to relational aspects of the nurse-patient relationship can be misinterpreted as niceties, rather than necessities that relate to meeting patient needs and mediating systems for them. These relational aspects, contributing to a nurse's identity from within nursing culture, may not be fully comprehended. Weinberg further elaborates that when nurses explain that they *know* their patient, it is actually a relational framing of nursing actions. They assess, assist, advocate, observe, interpret and coordinate multiple aspects of care, yet the language nurses use to describe their work rarely reflects the complexity of their work.

Gordon expresses concern that popular media attitudes suggest that "nurses don't really solve cases, they don't diagnose, so the stories can be more emotionally driven rather than science-driven" (Gordon 2010, p.xi). Gordon observes that nurses almost exclusively focus descriptions of their work on relational aspects of care, while "many neglect to mention that the nurse-patient relationship serves a set of instrumental goals – recovery, cure, coping, or

perhaps a decent death" (Gordon 2006, p.107). Identity is affected by couching the expertise of a nurse in an ambiguous coded language reinforced within nursing culture where there is a failure to communicate the connection between knowledge and the evidential and theoretical support for nursing actions. An inability to clearly state what nurses do in interprofessional care settings diminishes the role nurses play. Three decades ago, Hildegard Peplau, a noted nursing theorist of her time, identified the need for nurses to be clear about their performance or risk the disappearance of nursing itself (Browne et al. 2012).

Where is nursing?

For interprofessional to become a core competency of nursing practice, nurses need to embrace interprofessionality. However, relatively few nurses attend international IPE conferences[29] and fewer still present papers. At a nursing education conference with a focused segment specifically dedicated to IPE in nursing curriculum, many of the presentations demonstrated a lack of clarity in what IPE entails and how it fits in nursing education. A nurse from the UK, who had attended both conferences, expressed distress at the seeming lack of nursing engagement in the larger international movement of interprofessionalism and asked, "Where is nursing?" (personal communication).

This is an important question. Nurses can participate in the dialogue of interprofessionalism and challenge any resistance in the discipline or profession to do so. If nurses fail to engage in the discourse, there are significant risks of their being overlooked in the conversation about healthcare reform that is encompassing the trend toward interprofessionalism. The result could fracture care for patients and increase tensions between healthcare professions. Articulating the nursing perspective on the local and international

[29] Such as All Together Better Health and Collaborating Across Borders conferences.

interprofessional stage is a strategy whereby nurse leaders and educators could model engagement.

Cultivating a culture within nursing that supports an identity that encompasses interprofessionality can positively influence healthcare delivery and IPC. As interprofessionalism gains momentum, nurses have the opportunity to creatively reshape healthcare in an innovative and noticeable way.

In interprofessional workplaces, clearly defined and valued ways of explaining nurses' work enable individual nurses to have confidence to explain their roles, supported by reframed practice-relevant theory. Nurse leaders can become points of reference in healthcare system changes by providing support in interprofessional nursing practice environments, describing the work of nurses, demonstrating positive outcomes linked to nursing practice, and participating in research that documents and expands how nursing is theorized in interprofessional situations. Nursing educators can confront curricular and scheduling challenges that impede IPE and broader interprofessional clinical learning initiatives and change. It is vital that nursing education equip students for interprofessional practice through closely linked interprofessional and nursing competencies. Preparatory interprofessional learning and identity work position nursing graduates to perform collaborative and integrated care. Nurses can expand their own interprofessional competence through professional development. Being able to clearly articulate what nurses know and do in performing their role can be foundational in making nursing visible in the expanding interprofessional healthcare world.

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Chapter 4: Paper 2

Considering Performativity as Methodology and Phenomena

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Considering Performativity as Methodology and Phenomena in Investigating Interprofessional Healthcare Teams

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Performativity is phenomena and methodology. Understanding the concept, the evolution of the term and how performativity can open spaces for inquiry, adds to knowledge about interprofessional healthcare teams. Distinguishing between performance and performativity is essential. In this article, we examine methodological aspects of performativity through the use of forum theatre. Dialogue from a performance-based inquiry workshop with healthcare team members provides a way to discuss performative methodology. The workshop was built upon recurrent characteristics of interprofessionalism in healthcare teams seen in conversational interviews with healthcare practitioner participants. Performativity provides a way to explore the relational work in interprofessional team practices. The methodological messiness of performative inquiry is discussed.

performativity; performative methodology; interprofessional; forum theater; healthcare; performance, health sciences; nursing

1. Setting the Stage

The bright theater lights that flooded center stage produced long shadows in the peripheral wings. A group of healthcare practitioners had been together in a forum theater workshop for most of the day. The four participants on stage were in character, part way through a terrifying scene where something had gone terribly wrong in the treatment of the unseen patient.

> Practitioner Q: (horrified) This is on *you*.
>
> Practitioner C: (long pause … whispered) I know.

The emotions in the theater studio were tangible. It was an enactment of a composite experience that all participants recognized, and at that moment, responded to emotionally. It was the embodiment of repeated iterative performances of power differentials, hierarchy, accountability, ethics, broken processes and communication deficiencies played out in real time. Within the constructions of context, this enacted healthcare team was bound to its performativity. Performativity[30] in this work is understood as both phenomena[31] under study, as well as the methodology; by this we mean that performativity, as a theoretical concept, underpins both the methodological approach and the substantive focus of interest. In this article, we examine methodological aspects of performativity, whereby the being of healthcare teams becomes an example of performativity that is explored through the use of forum theater.

This exchange reflects part of dialogue in a scene crafted by participants; a storyline of fragmented teams struggling with reinforced differences in power and socially constructed ways of being team members and the nature of team workings. Questions about healthcare team performance call for a methodology that challenges representations of being an

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[30] *Performativity* appears in the writings of several disciplines such as economic sociology (i.e. how stocks and bonds respond to the market, see Brooke HARRINGTON, 2013), science and technology, anthropology (i.e. in examining rituals) and others. J. Hillis MILLER (2007) suggests that performative theory has become an interdisciplinary project, "an alternative name for what used to be called 'performative studies'" (p.225).

[31] *Phenomena* refers to multiplicity of understandings/implications/experiences of performativity.

interprofessional team and methods that bring together practitioners to co-create knowledge about their practices. Instead of looking for a way to imagine teams outside of an inquiry centered on semiotic approaches, the example project utilized methods that opened up discovery related to how healthcare practitioners interpret their situations and develop their perspectives (HODGINS & BOYDELL, 2014, §10). The methodology (performativity) and the methods (performance-based) invite new understandings through developing a place for the embodiment of imaginings and possibilities to address the complexities of interprofessionalism.

Consistent with a performative stance, the workshop dialogue was further analyzed using a performative theory (PICKERING 1995) and is discussed elsewhere (Sommerfeldt, forthcoming). The current article wrestles with the questions raised in the forum theater processes, describes some theoretical underpinnings and history of the term *performativity,* and discusses performativity as a force in healthcare teams.

2. Raising Questions

In the scene that introduced this article, a particular individual was demanding and unapproachable (Practitioner Q) yet was the self-appointed spokesperson to hospital administrators. In the context of the scene, a prescribed drug dose was thought to be in error by some team members (Practitioner C, Practitioner M) yet seen as aggressive but safe treatment by another (Practitioner T). Questions to Q were rebuffed. The result was a devastating patient outcome. Two practitioners (C and M), having previously offered opinions, are now silent observers of the tense interaction, busied in their individual work.

Would it matter in the interpretation of the dialogue if the profession or discipline of each practitioner was identified? What meaning changes if Q was an advanced practice nurse, C a

pharmacist and T a medical resident? Or what if Q was a pharmacist, C a physician, and the other two silent characters in the scene were nurses? What part does silence play in the exchange? What is silencing? Considering the team through performativity raises not only questions about being *on* a team, it questions and critiques *being* a team.

Such questions address performativity. Multiple repeated performances become entrenched in performativity, itself a concept and a methodology. Room to explore the poignancy of the moment and considerations related to being a team was made possible by forum theater methods. The aim of forum theater, a specific applied theater method developed from the traditions of "Theatre of the Oppressed" (BOAL, 1993) where the goal is to move the spectator into an actor, generate discussion, and "rehearse action toward real social change" (PENDERGAST & SAXTON, 2009, p.69). Forum theater is a performance-based vehicle to create "imaginative blue-prints for possible healthy futures" fuelled by the community's analysis of real-life experiences (GOULET, LINDS, EPISKENEW & SCHMIDT, 2011, p.96). It invites critical reflection of confronting power, domination, intimidation and social constructions that have a bearing on performance. Forum theater brings participants together to engage in theater games and actions to identify and analyze ideas and concepts. Through a process of iterative analysis, a series of collective stories create scenes that identify points of conflict leading to a crisis.

3. Forum Theater

To create a forum theater piece, interested members of a community come together with a theater expert in workshop style to explore a focused issue. To assist the group in becoming a cast for the play about the issue, the expert, called a "joker" in the world of "Theatre of the Oppressed," initiates and guides the group through theater activities. Augusto BOAL (2002)

uses the term "theatre games" that extend to creating a base play that contains a crisis which is acted out. The *forum* part is when audience members are invited to change the course of the play through intervening or interrupting the prelude or contributing circumstances that led up to the crisis, thus avoiding or ameliorating the crisis. Forum theater is not propaganda theater, nor is it didactic theater. It is pedagogical (BOAL, 2002) as the actors and audience learn together other approaches to address the original issue.

The scene at the beginning of the article materialized during a full-day forum theater workshop with members of healthcare teams interested in exploring the concept of interprofessionalism through performance methods. Prior to the workshop, each participant had engaged in conversations about the relational aspects of healthcare teams in an hour-long individual interview. Using Andrew PICKERING's (1995) concept of the "mangle," shown to be a useful approach in social science inquiry[32] (HEKMAN, 2010; JACKSON, 2013), SOMMERFELDT (2014) identifies points of struggle and points of insight in teams, as potential starting places for dialogue and scaffolding of processes.

4. Theoretical Underpinnings: Performance and Performativity

Over time and at different stages of the analysis it became important to attend to the theoretical underpinnings of performativity. In particular it became necessary to explore the current theoretical conceptualizations of the term *performativity*, and determine the difficulties associated with mistakenly using *performance* and *performativity* interchangeably. Practically, misinterpreting the concepts may result in overlooking places to disrupt confining practices, both

[32] PICKERING (1995) rejects the narrowness of semiotic approaches to scientific inquiry through theorizing a performative idiom over representation. He suggests that a “dialectic of resistance and accommodation” (p. 22) exists as a human and non-human “dance of agency” (p.21) which he calls “the mangle of practice” (p.23). HEKMAN (2010) extends PICKERING’s mangle as a “significant theoretical advance” to explaining the interactions of science, politics, technology and matter as “elements that impinge on almost everything we do” (p.25).

methodologically as well as the subsequent loss of potential ways of shaping healthcare team culture and theory. It may inadvertently overlay performativity in assessing individual performance on a team. Methodologically, it became important to distinguish these terms to create ontological possibilities for post-qualitative inquiries[33] (JACKSON, 2013). In this way, inquiring into, or doing analysis in/of/as performativity, cannot be separated from the phenomena of performativity.

A paradox appears in this discussion through arguing that performative research of necessity steps away from representation yet returns to representation through writing about the knowledge created through performative inquiry. Such a dilemma is considered in Peter DIRKSMEIER and Ilse HELBRECHT's (2008) treatment of the "performative turn" in social research. Similarly, others have drawn on performative approaches to "open up the possibility to gain understanding beyond the rational and cognitive" to "allow new and alternative perspectives and interpretations of a social situation" (BATTISTI & EISELEN, 2008 § 97).

4.1 Roots of performativity

Norman DENZIN (2003) suggests that "we inhabit a performance-based, dramaturgical culture" (p.x) where any division between performativity (the *doing*), and performance (the *done*) has vanished (CONQUERGOOD, 1998). The inquiry space opened through performance and participation invites methods such as forum theater as a basis for expanding understanding of human interactions. Performativity has at times been confused or perhaps co-opted as a

[33] Elizabeth Adams ST. PIERRE (2011) and Patti LATHER (2013) argue that "post-qualitative research" is a postmodern approach to inquiry that moves beyond humanist and codified qualitative approaches. ST. PIERRE (2011) calls for the "reimagination of social science inquiry" freeing research from qualitative approaches that have become "conventional, reductionist, hegemonic and sometimes oppressive", of "science that cannot be defined in advance and is never the same" (p. 613).

contemporary expression of the verb *to perform*. Performativity is not actually in the Merriam Webster dictionary, at least not yet. The word *performative* is. First coined in 1955 by linguistic philosopher J.L. AUSTIN in his speech act theory (AUSTIN, 1962), statements or utterances that describe (constative) and those that actually operationalize something through the utterance itself (performative) are identified. The neologism he created can be seen as performative itself in that it tied action (creation) with text (the word). While constatives are considered to be true or false, performatives are not bound by truth, but by intention.

For J.L. AUSTIN, when the utterance was consistent with the behavior, as promising to do something and then actually doing it, the performative nature of the utterance is primary or explicit (as in "I doubt that"). Implicit performatives are utterances that suggest the performative will hold or will at some time come to pass (such as "Really?" as an expression of anticipated or future doubt). J.L. AUSTIN did not tie the performative to a right or wrong (such as in "I apologize" with no way of knowing if it was warranted or sincere) but considered it to fail or be *unhappy* if it did not meet specific criteria. By separating performatives from truth or falsehood, J.L. AUSTIN attempted to situate statements with a connection to language and the social inter-activeness of words.

The adjective *performative*, from J.L. AUSTIN's phrase *performative utterance* found its way into philosophical discussions. John SEARLE (1969) furthered J.L. AUSTIN's notions in the late 1980s and the term fit the feminist conversations developing in the late 1900s. Eve SEDGWICK (2003) argued that performative utterances could be transformative within the dimension of time; immediacy or future change, through the utterance, were not exclusive. Jacques

DERRIDA (1988) disagreed with J.L. AUSTIN at many points in his early writings[34] only to actually shape his own perspective and eventually even use the word *performative* in a later writing (MILLER, 2009). Much of current attention to the word, as well as the further transformation to an abstract noun, originates from feminist theorist Judith BUTLER (1999). The suffix *ity* indicates a condition or state of the noun. Hence, performativity is the condition or state that accomplishes or indicates the future accomplishment of the statement.

It is acknowledged that John SEARLE (1969), Jean-François LYOTARD (1984)[35] and Eve Sedgwick (SEDGWICK & FRANK, 2003) had significant influences in the evolving construct of performativity. In this discussion, the perspectives of J.L. AUSTIN, Jacques DERRIDA, and Judith BUTLER are used to develop an understanding of the progressive and somewhat divergent uses of performativity as it relates to furthering an appreciation of components of being a team.

Insight into a crucial component in a healthcare team context, that of language and dialogue, can be found by returning to J.L. AUSTIN's first notions. His early writings placed the requirement of a performative utterance in the first person singular along with a verb that does something or implies action (AUSTIN, 1962). For example, saying "I promise …" encapsulates not only an action but the intention associated with the utterance. The word *promise* is not a simple description, but a commitment, making the statement performative. Healthcare teams use language and at times jargon that likewise binds words to performed meaning but in a first person plural utterance. "We agree …," "Our diagnosis …," "We commit …" are all ways in

[34] J. Hillis MILLER (2007) contends that the "concept of the performative that Derrida developed in his late work" came about through "exappropriation, that is, through a taking over by way of creative distortion, of Austin's ideas" (p. 231) in analyzing Derrida's writings in *Signature Event Context* and *Limited Inc abc . . .*

[35] LYOTARD's views are used in organizational theory to describe performativity as modes and techniques of regulation that mobilize comparisons in performance as a means of influence or control in the effective production of goods.

which the team, as a unit, operationalizes statements. A performative speech act does not necessarily bring agreement. "I deny …," "I condemn …," or perhaps using words to silence another, make evident potential hazards in speech acts.

This is a simplification of J.L. AUSTIN's work. Nevertheless, inherent in the language of being a team, is the performative force of language. While J.L. AUSTIN pointed out early flaws in dichotomizing utterances as only constative or performative, recognizing that usual language contained a little of both features in an utterance, healthcare team language that is limited to descriptions fail to operationalize the cohesive strength of some utterances. J.L. AUSTIN also recognized that a word spoken in jest or perhaps scripted for an actor would not actually have any force.

Acknowledging the influences of language on the implication of cohesiveness obliges the team to use intentional language and be aware of the possible connotative meanings offered to patients. This is of particular importance when one considers patients as team members in a collaborative care model such as one proposed by Carole ORCHARD (2010). Just as the "I" in J.L. AUSTIN's view assumes Self-hood, using "we" as a collective implies a somewhat established Self, the Team. Performative utterances contribute to being a team through subjectivity, a subjectivity that is highlighted in using forum theater. Through the imaginative work in forum theater, performativity also enables actors to try out observed and new language, as well as embrace silences and silencing as exposed traits in characters.

Jacques DERRIDA's views offer further guidance in exploring performativity of teams. In terms of the emerging understanding of the concept of performativity, Jacques DERRIDA (1977) bridges the seemingly disparate views of J.L. AUSTIN's speech act theory (1962) and present-day usage of performativity theory offered by Judith BUTLER (1999). Performative utterances

continue to be in force, regardless of how many times they are used, a fundamental quality that Jacques DERRIDA calls *iterability*. Refuting J.L. AUSTIN's assertion that conditions or circumstances must have certain parameters, iterability allows for open-ended possibilities. Jacques DERRIDA also includes what J.L. AUSTIN would label etiolated performatives—those without force—such as spoken through scripts of the stage or screen, poetry or humor. For example, in the script developed in the workshop, a pure Austinian interpretation of a performative utterance, "I know," could not be performative because it was voiced in a play. Jacques DERRIDA would consider it in force because the *character* uttered the performative, making it a true statement for the character. J. Hillis Miller, in exploring Jacques DERRIDA's views, suggests that the "possibility of the abnormal is an intrinsic part of the normal" (MILLER, 2007, p.230).

One of the extraordinary components of performativity in teamwork extends from Jacques DERRIDA's distinct handling of time crafted into the term *différance*. Différance, a Derridian performative in itself, clarifies past and present where the future hinges on performatives in the present. (This is only one aspect of *différance* used here to illustrate a point.) The example Jacques DERRIDA uses is "Je t'aime" (translated as "I love you"), which may not be a statement of fact, a constative utterance, but rather a performative with a difference/*différance* that establishes a condition of a new person, one in love with another person. Time is somewhat suspended in developing a future as the truth or falsehood of the statement cannot be known without endorsement of a return performative; in a state of being loved through a statement of love, *in* love, versus a constative declaration of one-sided feeling, *my* love (MILLER, 2007). In healthcare teams, "we" statements create conditional utterances of a new entity, a team, and suspend time for a reciprocal response to shape the future. Jacques DERRIDA calls it a "future anterior," an unpredictable "à-venir" meaning "to come".

The continual shaping of the future through team texts found in spoken utterances, gestures, posturing, etc. of a team is enactment of implications of both meanings in the double meaning of Jacques DERRIDA's *différance.* Jacques DERRIDA not only was playful in creating the homonym of *difference* by replacing the *é* with an *a*, he was deliberately calling on the reader (because the spoken pronunciation is not distinguishable between the two spellings) to make space for subtle yet remarkable changes to meanings—he created time for the consideration. The appearance of a "misspelled" word compels the knowing reader to pause, take notice, wonder if it is a mistake, and consider intentionality. Such may also be seen in the word *interprofessional*. It is a neologistic response to a new healthcare world, a word that implies a bonding, unification (no hyphen), newness, a *We*. The attributes of utterances point to further possibilities in understanding performativity.

Judith BUTLER's (1993) standpoint, which seems to be embraced as the contemporary description of performativity, differs. While J.L. AUSTIN coined the term *performative*, Judith BUTLER developed *performativity.* Merging Jacques DERRIDA's adaptation of J.L. AUSTIN's concept and FOUCAULT's (1980) ideas of power and political coerciveness of society, Judith BUTLER advances feminism and queer theory by generating *performativity theory*. She developed performativity theory on the proposition that gender is performative. Gender, not an inherent trait, becomes known as behaviors, shaped by society's pressures, are performed repeatedly. Her interpretation of performativity as it relates to gender suggests that behaviors and actions that are expressed and repeated, over time become the expression (BUTLER, 1999). Repetition is a key feature of how gender becomes socially constructed, the iterability.

The central concept of repeated behaviors (performances) is influenced by politics (societal demands) and prior texts (citationality). Extending this iteration of performativity to a group of

healthcare providers who are declared to be a *team* ("declared" could be considered an Austinian performative utterance), the repetition of the obligatory roles actually constructs a team through the forces that designate them as a team. These forces may be organic such as where professionals come together to provide care through a natural acknowledgement of symbiotically driven aims or may perhaps be formally structured within a healthcare system. Judith BUTLER clarifies that a hallmark of performativity is the "reiterative and citational practice by which discourse produces the effects that it names" (1993 p.2). It is not "theatrical self-presentation" or free-play, nor can it simply be equated with performance. “Performativity cannot be understood outside a process of iterability, a regularized and constrained repetition of norms. And this repetition is not performed *by* a subject; this repetition is what enables a subject and constitutes the temporal condition for a subject" (ibid.p.95).

5. Returning to the Stage

Memory carries a force in performativity. When a performance is captured in memory, it is an instant set in the moment. Over time, performativity emerges from citationality and iterability, shaped through social conventions, the "instance of an endless process of repetition" (BAL, 2002, p.179). Mieke BAL suggests that memory is a mediator of performance and performativity (p.199) as the repetition of collective memory becomes enacted in the "doing." In healthcare, it is the being of teams, embracing "*we* are on the line" in contrast to the scripted "*you*." The act of *being* a team is performative allowing a further ontological level where the "concept of performance alone cannot satisfy" (ibid.).

> Practitioner Q: (horrified) This is on *you*.
>
> Practitioner C: (long pause … whispered) I know.

In the segment of dialogue, the performative nature can be seen in several ways through multiple performance pieces in the exchange. Although the context involves the practitioners functioning within a team structure, the accusation of Practitioner Q suggests that power and accountability is directed at an individual level toward Practitioner C. The emphasized *you* is a separation from the notion of *we* as is the whispered *I*. The long pause creating a period of silence implies re-played moments of distrust, blame, rebuttal, longing for sharing, or some other aspect consistent with historically similar scenes. The whisper, a muted response, was tentative, offered submissively, filtered by the known unspoken history of being held to account alone and unprotected by camaraderie, timid and exposed. What about the other team member characters on stage? What welded them to their tasks as the dialogue unfolded, unmoved yet aware of the crackling sounds of a crumbling team? Could this crisis have been averted, interrupted or the circumstances ameliorated? What iterations of similar performances were influencing this particular moment and what procedural or conventional dictum was being cited in gesture through perfomativity?

5.1 Team context

The performativity of the healthcare team is bound to its social context through repetitious normative conditions produced by the context. Judith BUTLER's view suggests that the citational practices, the texts of the team (comprising language, gestures, acts, etc.) that are constrained by the context (the socially constructed tasks, identity, organization), are iterative—repeated (BUTLER, 1993). The result produces a way of being a team by enabling those same team texts over time (temporality) to create a collection of subjects: the team (FREEMAN & PECK, 2010). Team performativity is not the performed role of individuals on the team, rather, it is a resolution of Self and Other in reciprocal influence and resolution of contextual healthcare

cultural representations. A team's presence is a "cultural force that affects the lives of subjects" (BAL, 2002, p.197). The team work is relative, relational, and temporal, a rather unstable and changeable component of being a team.

Performativity theory, therefore, is useful to describe healthcare teams; individuals producing a collective of repeated behaviors as constructed by a social view within healthcare. Being clear about the linkages and distinctiveness of the words performance and performativity, and avoiding use of them interchangeably, frees up ways of discovering characteristics of healthcare teams in a new way.

In the forum theater workshop, team members were mandated to be a team (social structures); they revealed team behaviors (in this case mal-adaptive and dysfunctional), and communicated using a variety of texts (language, silence, gestures) that were known to them through repeated performances over time. Influences of power produced disjointed avenues of dialogue or rendered it in effect absent. Tasks were accomplished within a frame of operating that was well known to the team members yet became functionally frozen in team structures and processes, a product of collective memory. The performativity is not measured; it is a way of being. It is this way of being that is accessed through the ontological focus on performativity through forum theater processes. Practitioner C's whispered response, "I know," is performative, as the utterance drew in blame, ac*know*ledgement, betrayal, moral distress, and the unraveling of team performance. Repeated, filtered, accumulated acts of team were again performed. Team performativity was manifested in the speech act, memory traces and power contexts of the team. Here we see the interplay of methodology and phenomena close up.

Tensions around leadership, ways of approaching feedback and decision-making, personalities, assumptions and stereotypes are inherent in healthcare teams. The spaces between points of

struggle and points of insight reveal performativity. In well-functioning teams, the performativity is a negotiated trust, a shared knowing, an authentic together, much like it is explored through the forum theater experience.

Being a healthcare team is contextual. Each team exists in a unique circumstance, composition and purpose. The convoluted nature of healthcare and the multiplicity of components and characters require intentional processes and dialogue to develop and maintain an understanding of team performativity. While individual and team performances have expressions that can be observed, identified and perhaps even measured, performativity is negotiated in spaces of trust, experience, struggles and tensions. It invites thoughtful consideration of team identity, structures, behaviors, context and historical influences. The enactment of healthcare teams emerges from considering the theoretical conception of performativity, *being* a team.

6. Methods of Inquiry

The research project highlighted earlier explored the relational work that is involved in being in a healthcare team. The forum theater workshop was built on concepts of being on a team that surfaced in interviews and is part of a larger inquiry involving further analysis[36] that builds on Andrew PICKERING's (1995) work of the mangle (SOMMERFELDT, forthcoming) and methods of forum theater. Throughout the day, participants engaged in theater activities that resulted in expressions of emotion and descriptions of team identities, behaviors and functions. Facilitated

[36] Although this workshop was limited to healthcare professionals in practice, it is acknowledged that the need to have patients be contributing members of healthcare teams brings further complexity. A healthcare team is situated within organizational structures that shape the spaces in which the team exists. Tim FREEMAN and Edward PECK suggest that "[i]t is difficult to overstate the complexity of health care organizations" (2010, p.32).

by a theater expert trained in forum theater methods, the participants and researcher together described and challenged ideas.

Through forum theater methods, participants developed composite stories of their own experiences that culminated in the creation of scenes along a story line that becomes suspended at the moment of crisis. "This is on *you*." "I know." Here, the characters encounter difficulties. They identify points of struggle that are antecedents to the catastrophe and while doing so, detail some of the relational work done or left unfinished in their own healthcare team. Using performance as expressions of team performativity, the theater offered a place for co-created knowledges about processes and functions of team experiences. Through artful inquiry, a significant space becomes available where, "something new is possible—where disruption occurs and the new begins" (BERGUM & GODKIN, 2008, p.604). The transformation of points of struggle into points of insight is a co-experienced moment of shared epistemology.

6.1 Methodological messiness

As Mieke BAL (2002) suggests illuminating performativity as a concept contributes to an expanded view of the performance gap between what is thought from the perspective of theory and what is actually observed in practices, a theory-practice gap, by examining the "practice of theorizing" (p.177). This is a place where the concepts travel back and forth in the space between practice and theory in a "messy" way (BAL, 2002); perhaps it too allows for the messiness of methodology, methods, and mangling in post-qualitative work (LATHER & ST. PIERRE, 2013; JACKSON, 2013). The meanings of performance and performativity are severed and then re-linked through a third concept of memory resulting in greater clarity of the terms from their usual and casual use. For Patti LATHER (2013), producing knowledge differently in a post-qualitative era imagines and accomplishes an inquiry that is "embedded in

the immanence of doing" (p.635). Karen BARAD (2003) suggests that moving toward performative "alternatives to representationalism" (p.802) shifts the focus of inquiry to matters of practices[37]. This shift in methodology brings with it questions of ontology, materiality and agency (BARAD, 2003). Sorting out some of this messiness calls for clarification and careful consideration of the differences between the two terms of performance and performativity.

Inquiring into teams through performativity theory is rarely seen in healthcare literature. Discussing healthcare performativity, Tim FREEMAN and Edward PECK (2010) effectively use Judith BUTLER and Jacques DERRIDA's views to describe "performative misfire" (p. 34) in transformational cultural change in the National Health Service in England. Catherine MILLS (2013) describes the performativity of personhood in discussing ethical considerations in abortion. Jane GILMER, Paul MacNEILL and Tan Chay HOON (2013) are scheduled to present a workshop about techniques useful in "training the 'performativity' of doctors and healthcare professionals" at a conference in early 2014. Using applied theatre inquiry methods of performance (forum theater) to explore ways of *being* a team (performativity) advances the idea that healthcare cultural conventions can neither be stripped nor endorsed in the pursuit of gaining understanding of what it means to be, or fail to be, a team. Knowledge generation in an inter-disciplinary healthcare environment calls for methodology that opens spaces for insight into roles, distribution of power, system-established stakes, ethics, exchanges and many other aspects of humans practicing together with the intention of providing care and in pursuing health and well-being. Caring alongside and collaboratively working with other professionals and disciplines exposes new territory for theory development and knowledge creation. Theoretical

[37] This aligns with CONQUERGOOD's (2002) call in performance studies to "refuse and supersede this deeply entrenched division of labor, apartheid of knowledges, that plays out inside the academy as the difference between thinking and doing, interpreting and making, conceptualizing and creating" (p.153).

framing of interprofessional caregiving calls for research approaches that are compatible with the reality in which teams perform and the actualities of performativity.

An investigation of this sort lives in the borderlands of health sciences research where inquiry and healthcare practices intersect in inter-disciplinary spaces. The language of theater can be used to describe the involvement of practitioners in the lives of patients as well as their presence in a healthcare team[38]. Where Colin HOLMES suggests that nursing is a "praxis expressed through dramatic performance" (1992, p.947), healthcare team members likewise develop a team praxis and performance. Professional competence can be partially assessed by how tasks are performed. The language of performance and theatrical metaphors are consistent with the relational human experiences of helping others in their endeavors of advancing health. This interactive aspect of healthcare practitioners forging relationships in working together substantiates using arts-based inquiry into the performance of teams utilizing applied theater methods. Such methodology invites embodied understandings to be discovered and knowledge generated.[39]

7. Repeated Performances and Performativity

A non-positivist orientation places collaborative ways of doing research within a world view that is "based on participation and participative realities" (HERON & REASON, 1997, p.275). Having healthcare practitioners co-create knowledge about healthcare teams that is rooted in their own performances on healthcare teams, including performativity, has the potential to inform much

[38] The importance of including patients is recognized. In this article, the discussion is limited to concepts and examples of healthcare team members interacting together. The further complexities that accompany concepts of patient involvement are not discussed here.

[39] Arts-based research aims to experience embodied understandings to inform exchanged understandings and analysis among participants and the researcher(s). Conversations, dialogue, texts, images, and so on are all considered data.

needed interprofessional team theory and measurement. Repetitive individual and team performances have reciprocal interplay with team performativity.

It is necessary to recognize the interplay between intra-team relationship performances and performativity in interprofessional healthcare team success; this calls for clarity about team behaviors, language and processes. Nurses, for example, are increasingly practicing in interprofessional environments, necessitating ways to articulate nursing knowledge and presence in interprofessionalism (SOMMERFELDT, 2013). Other practitioners have similar challenges. Interprofessional healthcare team care frameworks involve inter-disciplinary practices, interprofessional interactions, team competencies and designations that differ from uni-professional care teams. Discovering team performativity is hampered where the concepts of individual or collective performance and performativity are ill-defined or misunderstood.

In the context of healthcare teamwork, performance may be seen as a measurement of how closely the team as a whole carries out its mandate in accomplishing the tasks associated with the team. This measurement may or may not involve objective quantified data, outcomes, observations or other subjective indicators that are evaluative means to judge the effectiveness of the team, including patient safety. Performance of the team may also refer to the observable behaviors of the team such as unity, cohesiveness and other such communicated aspects that demonstrate an enacted team. This is the presentation, or perhaps as Erving GOFFMAN (1967) may describe as "face," the seen part of teamwork, the public exhibition of the supporting pieces and players contributing to what the team has produced.

Viewing performativity as both methodology and phenomena allows for a reconsideration of the "face" and ultimately space of being a team that questions and enacts performativity. Using performance based methods of inquiry offers those in healthcare the prospect of exploring not

only their roles, but also the strands of their practices that through repeated performances, emerge as performativity.

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Chapter 5: Paper 3

In the Mangle of Interprofessional Healthcare Teams:

A Performative Study Using Forum Theatre

This paper details findings from the research. It was submitted and reviewed for publication in the journal *International Journal of Nursing Studies*.

Abstract

Background: Nursing practice increasingly involves interprofessional environments. The relational aspects of interprofessionalism are influenced through hierarchal structures, professional identity and patterns of performativity.

Objectives: The aim of this study was to explore dimensions of relational work in interprofessionalism. By examining performativity in teams through performance methods, I explored team workings with participants involved in interprofessional practices.

Design: Healthcare practitioners from a variety of disciplines came together as participants with a researcher and a theatre facilitator to explore teamwork and co-create knowledge about interprofessionalism using forum theatre. Interviews were held prior to the workshop to explore individual views of teamwork and were foundational to the structure of the workshop.

Participants: Practitioners currently practicing in interprofessional team environment were invited to participate. The interviews (n=8) and the theatre workshop (n=7) included practitioners from nursing, physical therapy, medicine, occupational therapy, medical research and alternative medicine.

Setting: The research was conducted in a large Western Canadian city.

Methods: A full-day forum theatre workshop offered participants the opportunity to enact and challenge behaviors and attitudes that they had experienced in their respective healthcare

teams. Throughout the workshop, aspects of professional identity, power, trust, communication, system structures and motivation were explored through enacted images and scenes. At each step, iterative analysis with the participants shed light on components of team function and brought new insights.

Results: The activities of the workshop were analysed using Pickering's theory of the *Mangle of Practice* (1995) to identify three mangle strands found in being a team: organizational influences, accomplishing tasks, and an orientation to care. Performativity was identified as having a bearing on how teams perform and how teamwork is enacted.

Conclusion: Forum theatre methods allowed practitioners to question and challenge power structures, traditions and obstacles to teamwork, and looking for new ways to imagine being a team. Interprofessional practice was found to comprise complex relational elements. Practice components were seen as strands within a mangling of human and non-human forces that shape team performativity.

Contribution of the Paper

What is known about the topic?

- Interprofessional teams are encouraged as a collaborative care approach by the World Health Organization
- Nurses are increasingly practicing in interprofessional environments
- Healthcare teams may struggle with processes and structures of interprofessionalism
- Interprofessional education for practicing professionals is lacking

What this paper adds?

- Insight into the realities of interprofessional practices
- Forum theatre can be used as an innovative health research approach to explore the performativity of healthcare teams
- Interprofessional practice entails complex relational elements, shaped by human and non-human factors
- Nurses as key members of teams, can shape team performativity through engagement

In the Mangle of Interprofessional Healthcare Teams:

A Performative Study using Forum Theatre

Background

The World Health Organization (WHO) concluded in 2010 that sufficient evidence supports interprofessionalism through collaborative modes of care. As well, the WHO (2013) document *Transforming and scaling up health professionals' education and training* calls for hastening educational and practice reforms including interprofessionalism. Yet, literature introducing the term *interprofessional* (IP) and research elucidating the dimensions of interprofessional and interprofessional education (IPE) was scant at the turn of the 21st century (Reeves, Tassone, Parker, Wagner, & Simmons, 2012). A Canadian framework was developed to support interprofessional competency-based care and education (Canadian Interprofessional Health Collaborative, 2010) and serves to inform the interprofessional competency framework of other countries (Schmitt, Blue, Aschenbrener, & Viggiano, 2011; Interprofessional Education Collaborative Expert Panel, 2011).

Relational aspects of practice were identified as a barrier for new graduate nurses to engage in interprofessional practices (Pfaff, Baxter, Jack & Ploeg, 2014). Interpersonal influences on role construction have a bearing on interprofessional interactions (MacNaughton, Chreim, & Bourgeault, 2013). Interprofessional collaboration-in-practice has been described as "more rhetoric than actuality" in considering ethical practices (Ewashen, McInnis-Perry & Murphy, 2013). Perspectives of the workings in interprofessional practices are beginning to appear in the literature. This study was shaped by questions such as, what can be understood about how professionals actually interact in interprofessional healthcare teams? What influences the behaviors and processes that become teamwork? This explorative qualitative study aims to answer questions about the relational work of interprofessional healthcare teams using forum theatre. Guided by the qualitative research reporting framework COREQ (Tong,

Sainsbury and Craig, 2007), findings are discussed in relation to Pickering's (1995) theory, illuminating conceptual strands seen through participant experiences of being in healthcare teams.

A reflexive start

I undertook this inquiry after several years of observing healthcare teams and working with student teams, to broaden the understanding about interprofessional team contexts and their influence in practice. This research is framed within performative methodology using forum theatre methods. I looked to performance to investigate healthcare teams through my experiences of seeing theatre open places of imagination and where exploring possibilities has potential for new understanding in ways that traditional inquiry methods do not. Needing further training, I completed courses and training in performance theory, discourse analysis, arts-based research, drama theory and Theatre of the Oppressed. Partnering with an expert in community theatre research methods offered me the opportunity to branch into performative inquiry to address questions of being a team.

Framework

Forum theatre is a mechanism to generate knowledge with community members through their explorations of power, socially constructed roles, emotions and tensions by creating spaces to probe practitioner realities and interactions. Rooted in Boal's Theatre of the Oppressed (1985), where theatre was used in communities to generate discussions and "rehearse action toward real social change" (Pendergast & Saxton, 2009 p. 69), forum theatre brings non-actors to a stage to co-create knowledge, insights and possibilities for change.

Crucial to the methodology in this inquiry is the philosophical underpinning of performativity. This concept, as developed by Butler (1993, 1999) remains closely tied to the

origins as imagined by Austin (1962) and refined by Derrida (1988) in the context of interprofessional healthcare teams. Performativity is the coming together of dynamic forces that play out in performances of the individual team members and the team itself. Comprising language, structure, behaviors and context, performativity can become obscured when investigating team function is limited to examining performance through language alone. Insights about team workings emerge through the performative frame of theatre methods. With performativity as a key element, the forum theatre process becomes a mechanism to analyse discourse, movement, and representation in exploring relational aspects of teamwork.

Discovering aspects of practice by exploring performativity includes seeking insight into individual and team behaviors. Repeated performance is an expression of restored behaviour that is "symbolic and reflective"[40] (Schechner, 2002, p. 36), reinforcing meta-messages within a healthcare system. When a healthcare provider performs an assumed role, it could be explained as *Me* behaving "'as I am told to do' or 'as I have learned'" (Schechner, 2002, p.28). The performative aspect of healthcare teams contributes to cultural rituals comprising language (jargon), masks (nametags, white coats, uniforms), and performances on cue that elicit conditioned responses (hierarchy and reinforced positions often including subservience).

Methods

Forum theatre is used to involve members of communities in finding collective understandings and avenues to imagine change. The process involved presenting participants with focused and shared concerns, after which meaning was explored through discussion. This method entails a theatre facilitator working with community members to craft scenes into a play about their community concerns. As part of the meaning-making process, participants were

[40] Schechner (2002) suggests that behaviour stems from "material" of processes known and unknown over several "rehearsals" that are separate from the individual who is demonstrating the behavior, suggesting that when the behaviour is manifested is it the "second to the *n*th time" (p.36) and is therefore, restored.

invited to offer stories related to the central idea of relational work involved in being a part of an interprofessional team. These participant stories were then developed into image theatre vignettes. After the shared stories were portrayed in images, participants decided as a group which stories to take further. The refined and composite story was explored through animating the image. This was done by the facilitator who asked for words, thoughts, and next steps of each of the characters in the image. From this, short scenes were staged and a play developed.

The play does not end at the resolution of the issues but instead, at the climax where the protagonist is sure to fail without some type of intervention. After the play is performed for others, the audience has the opportunity to intervene and change what happens in the play. Looking for and rehearsing different ways that community members respond to shared challenges holds the possibility of different outcomes. With the help of the theatre facilitator, an audience member, called a spect-actor (Boal, 1985), requests a re-run of a particular scene and takes the place of one of the actors to change something that they believe to have a bearing on the outcome.

The style of forum theatre used in this research was influenced by a variation known as *Theatre for Living* (Diamond, 2007) that expands the interpretation of oppression and extends possibilities for transforming conflict. The theatre component is facilitated by an expert in the theatre method, whom, in Boal tradition, is called a *Joker*. Jokering is a well-developed facilitating role (Pendergast & Saxton, 2009) that combines theatre and dialogue, questioning and guiding exploration of the issues and environments that contribute to a situation. In this study, the theatre facilitator in the role of the Joker, worked closely with me. We met frequently to analyse data, prepare for the theatre workshop, and ultimately produce a play with the participants to advance conversations and understandings about aspects of being in a healthcare team.

The analysis is guided by Pickering's performative theory of *The Mangle of Practice* (1995). Pickering's theory rejects semiotic representation, arguing that scientific practice is open-ended and reciprocal in "a dance of agency" (Pickering & Guzik, 2008, p.vii). He claims that scientific practice needs to be decentred with respect to human and non-human agency in a process that he named *mangling*. This theoretical foundation is valuable in the analysis of the theatre experience data to examine interprofessionalism and healthcare providers as they negotiate care decisions. Pickering explores symmetrical and constitutive engagement of humans and non-humans with the world. The emerging intrinsic temporality in that intersection invokes an "ontology of becoming" (Pickering & Guzik, 2008, p.3). With such a lens, I examined the interplay of people in healthcare teams and the structures, systems and culture in which the team exists.

Ethical review

The project was reviewed and approved by the university ethics review board. Participants offered informed consent and were aware that they could withdraw at any time.

Participant selection

Potential participants were informed of the project through handbills and posters, word of mouth, personal emails and phone calls, and the listserve of a *humanities in health* interest group. Individuals from varied disciplines and professions practicing in existing healthcare teams were purposefully invited to participate in this research project. Practice sites in healthcare with current interprofessional team structures in primary care, rehabilitation or active treatment were of particular interest.

Purposeful recruitment of diverse health professions was desirable to provide varied and relevant perspectives about authentic healthcare teams. There was little response from

practitioners in primary care, an interesting situation given that the move toward team-based approaches to care is widely visible in primary care settings. Most responses came from clinicians in rehabilitation and acute care. I fielded calls and emails of persons wanting more information about the project. About 40 individuals expressed interest in participating with 8 contributing through interviews and 7 engaging in the full-day theatre workshop. The eight participants included: nurses, a physical therapist, medical researcher, nurse practitioner, alternative medicine practitioner, physician and an occupational therapist. Interviews provided a foundation for structuring the theatre activities.

Setting

The conversational interviews were held in public spaces, such as a coffee shop or in a private office. A full-day workshop was held in an arts-based research theatre studio on a university campus. This studio has a large instructional space in one half of the room; the other half is a fully functional theatrical stage complete with lighting, sound booth, catwalks, black flooring, acoustical sound, and various configurations of black stage curtains. The intimate theatre space provides an atmosphere of stage authenticity. The video cameras were positioned in the stage wings to be as unobtrusive as possible. During the workshop, a research assistant and two videographers were also present in the studio.

Data collection

Multiple methods of generating data (conversations, workshop activities, forum theatre interventions, field notes, recordings) were employed. I 'trouble' the word *data* and its use in aesthetic inquiry such as this research. *Data* implies an objectified piece of information whereas arts-based research aims to experience embodied understandings to inform exchanged

understandings and analysis among participants and the researcher(s)[41]. To align with convention, I refer to data in this article acknowledging the interplay of data and analysis in research processes.

Intentional reflexivity is acknowledged in field notes, interview prompts and the iterative analysis during the workshop. The data from these sources was used to elicit close examination of components of teamwork and explored beginning insights into the relational work of interprofessional teams. Additionally, conversations within the workshop and creation of staged scenes provided the opportunity for participants to reflexively make clear a transformative awareness of their own realities in practicing on teams.

All of the interviews were transcribed. The workshop activities that led to scene development were structured based on iterative analyses of earlier data from the interviews and review of the audio recordings. Video recordings captured the discussions, rehearsed scenes and the play that developed over the one-day workshop. The scene development dialogues and conversations were video recorded and transcribed for reference in further analysis.

Throughout the workshop, participant ideas and themes were written on posters and the emerging ideas were tracked and reworked on a large whiteboard. Emerging topics were verified by the participants and further explored in group discussions facilitated by the theatre facilitator in creating the scenes.

Conversational interviews

The loosely structured interviews with guiding questions were conversational in nature and open to be led by the participant (see Table 1).

Guiding question	Additional Prompts
What is your experience working in your team?	

[41] Lather (2013) suggests that "post-qualitative research " imagined as "embedded in the immanence of doing" extends alternative methodologies that are "non-totalizable, sometimes fugitive, also aggregate, innumerable, resisting stasis and capture, hierarchy and totality, what Deleuze might call 'a thousand tiny methodologies'" (p. 635).

What do you understand a team to be?	
What was it like to grow into a team?	
Based on your experience, what works well in a team? Was this experience shared by everyone?	What are some instances or times where you experienced your team working well?
What are some of the struggles in working as a team? How do you resolve struggles?	What are some instances or times where you experienced your team not working well?
How does it feel to leave a team?	
How do you imagine a team can be?	

Table 1: Guiding questions

Aspects of teamwork that were identified in one interview were introduced to other participants for their reflection and consideration. For example:

> Researcher: I'm wondering - we've heard some of the other participants talk about comfortable tensions that exist [...] It's just part of how they see working in a team; you're going to have some tensions. Is that your view?

Such looped-back triangulation is consistent with theatre research methods. Using individual conversations in place of prolonged interaction usually seen in multi-day workshops, including discussing other participants' notions, is similar to principles of participatory action research where participants are involved in a process of "praxis with phronesis" (Fals-Borda, 2013, p. 165). This engages the participants in a continuous movement of reflection and action with the intention of shared understanding. In this way, interview conversations created a type of asynchronous workshop of ideas. The potential points of struggle that surfaced in the interviews were grouped as struggles with administration and structure, struggles of practice including roles, ethics, attention, communication, team interactions and unity, and struggles of performance, which included the need for patient involvement with the team, assessment, and patterns of team function. These struggles informed the subsequent development of the theatre play.

Analysis Methods

The analysis proceeded in three discrete steps: 1.) following the interviews (pulling forward themes); 2.) iteratively during the theatre workshop; and then 3.) after the theatre experience. The analysis discussed in this manuscript focuses on findings using a performative stance (Pickering, 1995) to explore the mangle of interprofessional team practice.

Forum theatre methods require iterative analyses throughout workshop preparation and the play by the participants. Such participatory research acknowledges the "inherent capacity for participants to create their own knowledge based on their experience" where "popular knowledge" is "taken in, analyzed and reaffirmed or criticized" (Conrad, 2004, p.15). Forum theatre animation through participant intervention explores the issues raised in the scenes. Each reconsidered scene demonstrates deeper insights and intentions in the portrayal of characters and plot development. Forum theatre takes participants to a point of crisis and then works backwards through foreshadowing struggles to examine contributors that lead to the climax, an ongoing and iterative co-analysis by the researcher and participants. For the purposes of this research, the audience was composed of research participants.

Strands of the mangle

Further to the iterative analysis that occurred during the workshop and play, aspects of relational work were further explored by reviewing the transcripts and video recordings. This analysis is a non-traditional post-humanist approach based on Pickering's (1995) description of the *mangle in practice*[42]. The *mangle* is a word used by Pickering (1995), a social scientist, as both a noun and a verb. As a verb, it refers to the constant negotiation of agency. As a noun, it names the performative nature of practices, metaphorically similar to the mangle of a wringer-

[42] Pickering (1993, 1995) challenges actor-network theory through highlighting human and material agency. By rejecting semiotic representation, Pickering argues that real-time is a consideration over a traditional retrospective view of science. Such requires a shift from representational to performative.

style washing machine that extracts excess water from wet clothes when fed through the tight-fitting rollers.[43]

Pickering (1995) rebuffs the semiotic narrowness of scientific inquiry that privileges language, theorizing scientific practice through a performative idiom rather than a semiotic representational one. According to Pickering, human agency in practice seen as "gestures, skills and so on" (p. 17), come together with non-human "machines"; mechanical entities or systems that are "set in motion and exploite[d]"(p. 17). Human and non-human agency becomes "constitutively intertwined" when they are "tuned", influenced by social relations and other "cultural" workings, to be interactively stabilized in practice in the "dialectic of resistance and accommodation" (p. 25).

Points of struggle in the scenes leading to the crisis of the play make evident aspects of the healthcare team practice mangle. I call the components that were identified by participants in creating scenes for the forum theatre, *strands*[44] in the mangle of practice. These strands are components that explain parts of the relational work comprising interprofessional team performativity.

Multiple strands appear in the mangle, and those three identified in this analysis are some that were exposed in this particular exploration. Because the strands are intertwined, they cannot be pulled out of the mangle, and need to be explored in relation to practice. Metaphorically, the mangled strands may intertwine in ways that build a cord, with elements of

[43] *To mangle* may also represent destruction, and perhaps the image of destroyed team-ness is applicable here as well as in "The teamwork was mangled by individualism…"

[44] The term is influenced by language in narrative inquiry where "resonant threads" are identified in participant narratives. Here, the *strands* are complex themes that intertwine as larger concepts emerge. Human and non-human agency are considerations as systems within healthcare such as power, hierarchy, and administration interface with human dimensions such as emotion, culture, language and skills.

accord and *discord*, or may remain entangled, existing in the complexity of the interprofessional context[45]. Tensions are present and acknowledged.

Findings

The initial components that resonated for the participants in the interviews helped to structure the theatre workshop in relation to aspects of roles, unity, relationships, language (communication), ethics, competing attentions, and patient contributions.

Images

Image theatre processes began the workshop. Participants sculpted the images from their own experiences, some of which were also raised in the interviews. Creating image tableaux familiarized them with exploring healthcare team experiences in a performance mode. New understandings came by expanding the images through facilitation including animation, movement and by characters expressing emotion through language by making a statement or wish for the character. All images were created along the themes of teamwork and relationships within healthcare teams. Image 1 portrays a disconnected team engaged in tasks individually.[46]

[45] As with most metaphors, the concepts of "mangle" and "strands" begin to unravel at some point. Questions arise as to the materiality of the mangle itself, such as what exists between the strands? What are the boundaries or limits of the mangle?

[46] The photographs are not of the participants but were re-enacted by volunteer actors for this manuscript. The staging is taken directly from the video-recording and photographed in the same theatre location used in the research.

Image 1: Separate tasks

It is interesting to note the physical separation of each person. Tasks are being done independently and backs are turned to colleagues.

The characters in Image 2 are a physician and a nurse practitioner. The tableau was an early expression of team experiences between the two healthcare providers. The nurse practitioner was attempting to "hold ground" in an emotion-filled conversation.

Image 2: Holding ground

The aggressive expression of the nurse practitioner and the lecturing gestures of the physician portray increased withdrawal from relational engagement conducive to collaboration. It makes visible the tensions between the two practitioners. Donna[47] commented on the image that, "it's about winning so there's no team there anymore, there's nothing, it's severed, it's completely severed."

Participants in Image 3 are focused on accomplishing tasks over team cohesiveness. There was a clear disconnect between team responsibilities to assist and in achieving individual tasks.

Image 3: Disconnected

Distance and disconnects are seen in the presence of a pressing patient need which is at odds with accomplishing tasks by the person sitting and looking to teammates with expectation. The lack of movement was interpreted as a lack of interest in helping even though tasks were framed as aspects of caring.

The Play

[47] *Participant* quotes are identified with a pseudonym. Dialogue from a scene in the play is in script form attributed to the *character* speaking.

The image theatre exercises presented the participants with new ways to discuss and analyse aspects of their team experiences. They found that some of the similarities of their narratives revealed in discussions came together in a story about an adverse patient event that occurred on one of the participant's units. The sequence of events leading to the troubling event included dysfunctional team processes, fractures in team communication, uncertainty about roles and ambiguity about team function. The story was shaped into 5 components that each carried some degree of struggle that became scenes of the play.

The characters of the play were a nurse leader, a newly hired staff nurse, a physician and a unit clerk on an acute care hospital unit. The storyline followed a team meeting that discussed the challenges of being short-staffed and having a new staff member being oriented. At the team meeting, the physician dismissed the concerns as a nursing problem. Later, a crisis brought the physician back to the unit because of an adverse event, the result of administering a questioned medication dosage. At the height of the crisis, the senior nurse was in a volatile dialogue with the physician, the unit manager left the area to avoid the confrontation, and the new staff member was frozen in uncertainty (see Table 2).

Scene synopsis:

Scene 1	The nurses and unit clerk are gathered in a meeting room engaged in friendly banter, waiting for the physician to come to the weekly team meeting. The physician rushes in, appears to be in a hurry, uses sarcasm, controls the conversation yet remains standing and distant during the exchange.
Scene 2	The nurses are spread out across the stage working independently and the physician is off to the side. The nurses and unit clerk statements verbalize being overwhelmed with tasks; the physician makes a statement about wondering what the unit would do without the physician being present.
Scene 3	The nurses and clerk are at the nursing station looking at and questioning a physician order for a medication. The senior nurse phones the physician who is positioned at a far side of the stage as if in another location. This is not the first call regarding the order. The questioning is met with terse responses, and the physician is unmoved, explaining that he is busy with other patients and hangs up.
Scene 4	The senior nurse approaches others for some assistance and support in giving the medication, but is met with colleagues who are overwhelmed with their own tasks, unable to assist.

Scene 5	The senior nurse frantically nurse rushes to the nursing station and the upset physician hurries in wanting to know what has happened that he gets an urgent call back to the unit. The terrified nurse explains the adverse reaction to the physician. The other nurses are shocked but busy themselves away from the centre of the stage, not knowing how or if to enter the exchange. The angry physician berates the nurse and points out that the problem "is on you!" The nurse is looking down and silently acknowledges that it is. The play ends in this moment of heightened emotion and conflict.

Table 2: Scene Synopsis

For effective forum theatre, the participants strive to comprehensively understand the characters that they are playing by reason of actually being part of the community grappling with the issue (Diamond, 2007). The task of the group is to "find the crisis of their play and work backwards, moving their characters out of the crisis" (p. 114).

The first scene involved a team meeting where everyone is present and waiting except the physician. When the physician enters and reminds the team of a full schedule, wanting to get right to the crucial discussions, the new staff nurse expresses high expectations of teamwork that are quickly met with skepticism. (See Image 4)

Image 4: Scene 1 - Team meeting

During scene rehearsals, jokering the first scene brought out details: the team meeting is held weekly, there is a culture of dread, always the same person dominates, individualistic

problem solving, lack of formal mentoring for new staff and the suggestion that arrogance is actually a lack of confidence and related to domination. The image too, makes visible the hierarchical structure and disconnect between team members.

In the second scene, team members are attending to tasks individually, each overwhelmed with the volume and isolation of what they need to get done. The physician adds to team dysfunction through disengagement and insensitivity. During the third scene, some team members demonstrate collaborative behaviors of a team within a team through encouraging the person with the most power to question a drug order. There is a sense of patterned responses and repeated performances of powerlessness in the nurses when attempts at amicable clarification are rebuffed by the physician. By the fourth scene, the nurse is becoming desperate about being unable to solicit support, fearing for the safety of the patient. Colleagues are understanding yet consumed in their own activities, using distance as a protection. The emotion and tension of the play builds as the hope of teamwork vanishes in the final scene. After a patient dies from a medication dose, the furious physician holds no regard for team structures and assigns blame. The other team members are speechless and have no processes to use as strategies or tools in dealing with the crises as a team. Alone and ashamed, the nurse, with a bowed head softly whispers, “I know.” Everyone on stage is frozen in postures of animated terror. There is palpable silence on the stage. The dysfunction that fed the crises has exposed the broken team.

Following refinements and rehearsals of the scenes, the play is ready. After the theatre facilitator explained the process of forum theatre interventions, the audience was told that the play is about healthcare teamwork, but not given a synopsis of the scenes or a storyline. It is run without interruption and the performance maintains the tensions and passion seen in the rehearsals.

At the end of the play, an audience participant was invited by the theatre facilitator to comment on any observations or ideas about the play[48]. This participant, a healthcare professional with hospital administration experience, pointed out how "conditioned everyone is. And how, as I see it, …disconnected to how you're feeling, your own conscience about every decision…[E]verybody's overwhelmed and is responding in a different way" (Audience member). It was pointed out by the audience member that perhaps the physician's response to being overwhelmed is manifested in an authoritarian autocratic style, and that the others came together in a relational way. The conditioned roles of the nurses may prevent them from stepping out of the imposed hierarchy that restricts offering their perspective.

The theatre facilitator opened up the discussion for ideas about what "one of these characters could do differently to veer this sinking ship in a different course, in a different way" (Theatre facilitator). It was suggested that the senior nurse was

> "…disempowering to the whole team dynamic…the new team member, her ideas are sort of shuffled away, put down almost. The dysfunctional dynamic was spoken to right at the start… just 'there's absolutely nothing we can do about this and he's this way'… If the [senior nurse] had taken the role…and included this new team member and maybe had just a little more skill in being confrontational with the doctor that her teammates could feel supported and they might have more strength as a group as opposed to [individually]". (Audience member)

So what would a different approach be like? The theatre facilitator invited anyone to offer an intervention at any point of the play. With the theatre facilitator, the participants take the play back to the first scene with the team meeting. An onstage participant suggests, "I think one of us [characters] could have at least maybe asked him [the physician] to sit down. 'Would you want to join us, maybe?'" (Shannon). The theatre facilitator ends the discussion to try that suggestion, changing the scene by re-running it with the new approach, a process that defines forum theatre.

[48] One research participant came forward as an audience member and was not part of the workshop activities.

Setting up the intervention, an empty chair is incorporated into the scene. The characters decided that the new nurse will invite the physician to sit in it before the meeting gets underway. The characters are asked to remain in character, and to respond as the characters would in re-doing the scene. The empty chair seemed like a small change. The participant playing the character of the physician was caught off-guard by the gesture to the chair and the invitation to sit, the other team members unsure about what might happen next (see Image 5).

Image 5: Invitation

It disrupted the usual team behavior. Taking the opportunity of sitting changed not only the physical arrangement, but also the speed of the dialogue, where the physician character was looking and giving attention, and the emotional tone of the meeting. Participants set the scene, including the physical arrangement of the chairs according to previous team experiences. The physician is seen as being apart from the rest of the team and carries on a conversation with team members in a confrontational and power position. The chair for the physician is placed in a position of leadership as opposed to a space for the physician among the team members.

The theatre facilitator explores the situation further by discussing what is going on in the team:

THEATRE FACILITATOR:	What happened differently? Who instigated it and what happened, … how did it feel?
RESEARCHER:	Some resistance?
THEATRE FACILITATOR:	OK. Still asked the doctor to sit down.
RESEARCHER:	It seemed to work.
DONNA:	Yeah. I guess it was like getting a shot of cold…differently? Well, the word 'we'. [Short staff] came up a few times so the doctor was included in "we"…
BONNIE:	Within the system [physicians] typically have more clout, so if they're going to say, 'I need that - that's listened to.
SHANNON:	More than us [nurses].

Figure 1: Transcript

The acknowledgement of having "clout" with administrators was not seen as neither exploitive nor helpful in building team identity. The aspect of power differentials were acknowledged as part of the realities of current practice. Participants to this point had been pessimistic about having capacity to realize any influence or mount any challenge to power structures. Three of the five scenes in the play involved power differentials and were centred on disengagement or distance within the team.

Discussing the differences in the original team meeting scene and the new scene with the intervention, participants related to a newness and hopefulness in being able to look for ways to have meaningful and authentic dialogue within teams and with others who have influence on the structures in which their own team operates.

DONNA:	Well, and that's the dynamic. That is the dependent sort of the cycle …it's created…with all the roles and that's what happens.
SHANNON:	No one really likes it.

DONNA:	Yeah, that's right
SHANNON:	And I think a new person coming in, if they're the right person, can really help.
BONNIE:	Yea, I think it would change the dynamics between the two, sticking somebody new in that new energy.
RESEARCHER:	Is that what you're talking about? Just the disruption?
DONNA:	Yeah, it's like somebody's throwing a wrench into it…there's a system happening and somebody does something different. Somebody's set the different boundaries, somebody does something different …and I've got to respond to that in some way, so hopefully it moves the energy in a different way. I sit down and now the whole thing's changed.
AUDIENCE MEMBER:	Playing on [the new staff member's] innocence was important because it allowed people to realize or speak to what they were just taking for granted. Everybody was just taking for granted that everybody knew how this would affect the day but nobody was actually speaking to it…you were able to open that up, just very innocently, by 'well, how does that affect our team?'...
AUDIENCE MEMBER:	…in the healthcare team the common denominator is some form of caring. So no matter how role-stuck people are, or arrogant or power hungry, or whatever, if that genuinely can be spoken to, I think maybe people's issues can soften a little bit…
SHANNON:	And if [the physician] sat down once with us to talk, he may come and sit down again at the desk, 'cause it's is a two way street, it's like…a dance back and forth…it just changes the whole dynamic between us…

Figure 2: Transcript

The discussion extended to caricatured stereotypes and how interactions can reinforce behaviors. A caricature can be considered an inanimate part of interactions manifested in the ineffective patterns of the team. Repeated performances of the team members embracing caricatures of other team members becomes routine, part of the performativity of expecting non-engagement and indifferent responses. Participants recognized that being part of a team usually meant being assigned to a team. Imagining how the team could be different was a

difficult task for them, as some of the barriers seemingly impossible to counter. The scene from the play, the audience intervention, and discussion are provided here as one example from the workshop process that took place in the course of multiple interventions with each scene. The discussion that follows draws on all the performative discussion that took place throughout the workshop.

Discussion

The forum theatre process demonstrates three identifiable strands in the mangle that were exposed by the participants; organizational influences, accomplishing tasks, and an orientation towards care. These strands appeared in more than one scene, exposing different components of the strands.

Mangle strand: Organizational influences

From the first image theatre activities to the final discussion of the forum theatre play, the detached and cautious ways in which healthcare team members and administrators interact appeared. The participants talked about administrators often being away at meetings rather than being present on the unit and available to them. "[The nurse in charge] is probably at a meeting. Sorry." (Shannon). The participants laugh out-loud with the remark, knowingly nodding their heads. In discussions, they acknowledged varying influence of power-holders, suggesting that physicians have "clout" with hospital management. Some spoke of being called a team yet were a team in name only, lacking effective team structures and processes. Expressed concern about disengagement from team members and administrators was a recurrent strand throughout many of the images and discussions.

Adequate and appropriate staffing was acknowledged as important to being a team and appreciated as an administrative challenge. Associated with being disconnected, participants at times viewed management as being "just on a completely different page, no understanding

between the manager and the staff member - but she's all nice and smiley" (Shannon). As seen in the first intervention, a new staff nurse is a catalyst for change in disrupting unhelpful patterns of interacting. New staff, described by Shannon as "new blood" that "would change the dynamics…sticking somebody new in - that new energy" (Bonnie) can bring refreshing idealism. This, however, takes time and mentorship for new and novice members of healthcare teams to realize performance expectations.

Participants also believed that managers and administrators have a genuine interest in teams being effective in their work. Although disappointments and frustrations with organizational influences were apparent in the tableaux as well as in the play, the potential for finding effective ways of being a team became evident in the forum theatre interventions. This aspect of being a team is further explored in the strand identified as *orientation to care*.

Mangle strand: Accomplishing tasks

Participants viewed their own practices of skillfully accomplishing tasks to benefit patients individually which at times was at odds with teamwork. Donna suggested that understanding the tasks of team work involved connection within the team that took intention and time; "Trying to touch base. To connect" (Donna). "It's part of how I do my job 'cause I need to know what the energy is of my team members" (Pat). Several of the images had themes of fractured communication, power imbalances, and anger. Competitiveness brought struggles; "I'm going to win this, I will win this at all cost!" suggested one interpretation of another's frozen image.

Behaviors that blocked team cohesiveness came from disregarding or being unaware of each other's contributions. "[S]he's off doing whatever that's got nothing to do with the fact that there's care, her immediate care, so she's just doing some whatever role [when her teammate is non-verbally communicating] 'Really? Can't you see what's going on?'" (Bonnie) "Oblivious." (Donna) "… [A]t the end of the day, it was just he assumed we'll take care of it, I think, he took

us for granted. And we didn't speak up, we kinda covered for him 'cause we like him…so we had a good sense of team in some ways, but in other ways, it was really a struggle." (Donna)

Participants voiced confusion in how to interrupt the environment or culture that has developed in their areas of practice. When individual roles are over-emphasized, teamwork becomes hollow, "façade" (Shannon), such as when one participant who tried to elicit a collaborative approach was met with the response, "Don't ask questions, just do your job" (Donna).

Mangle strand: Orientation toward care

Underlying many of points of conflict was the authentic desire to provide care to patients. Early in the workshop the discussion turned to the idea that being a team meant purposefully being in touch. "As a healthcare professional, I have to intend to touch base with people" (Donna). Caring not only involves interaction with patients, but team members as well. "Like, we have a lot of care and compassion for our patients or our clients and sometimes I think we forget to extend that to one another, 'cause we get so busy doing what has to be done." (Pat). Having permission to disrupt policies or system traditions was something that was acknowledged but not explicitly done without reservation. "I need to speak up for myself – so having permission and clearly defined permission is really…valuable to teams" (Pat). "[I]f she hadn't [given me permission to withdraw from an activity] at the beginning, I probably wouldn't have. I would have just stuck it out." (Shannon).

Referring to not having "permission" to refuse an assignment in giving care, Gail suggested "…[Permission] is there often in tacit unspoken terms but sometimes we haven't heard that as individuals and so it's important to come back to the managerial or the team group that those are spoken, so that there's no question". This veiled foundation of having or needing permission to voice positions about care decisions was made explicit in the final play when the

audience member intervened by questioning the motives of the healthcare providers for being in the team at all.

Tensions between team members were discussed not only as professional interaction, but in a sense of not wanting patient needs to go unmet. “Could you just come out on the floor, do your job ‘cause I’m having to cover for you” (Donna). “‘Do you want me to do your job?’ - one of our [physicians] said that all the time” (Shannon). In the finished play the dialogue between a senior nurse and the prescribing physician failed to resolve the issue of dispute, yet at the core was a desire for a positive patient outcome. The patient, the very reason for the team to exist was not a character in the play, but was an unscripted reason for the five scenes. This parallels practice where the complexities of systems and human interaction become a counter-focus to the person receiving care from the team.

The orientation to care becomes overlooked in attending to more obvious requirements of establishing teamwork. The facilitator asked if having a new person on the team has an effect on team processes. “[M]ost of us are – we’re in healthcare ‘cause we’re good people, or we want to be on teams…But you lose sight of it. So just reminding us of what our [reasons are through having a new person who is idealistic]” (Shannon). In constructing a scene for the play, the participants created a dialogue that attempted to engage the physician in using influence or power with the administration in the challenges facing the team. The senior nurse raises the idea of patient safety in response to the physician, drawing attention back to patient care.

Using a performative theory of practices, team members participating in theatre methods identified perspectives of teamwork previously under-recognized. Each strand of the mangle is performed in team interactions and practices. These repeated performances of mangling became the performativity of the team.

In the mangle: Resistance and accommodation

The practice mangle can be further explored by examining movement within the strands described by Pickering (1995) as resistance and accommodation. Where healthcare providers are the humans and systems and structures the non-humans, the *dance of agency* of the two takes the "form of a dialectic of resistance and accommodation" (Pickering, 1995, p. 22).

Resistance is the "failure to achieve the intended capture of agency in practice" (Pickering, 1995, p. 22), a "practical obstacle" (Pickering, 1993, p. 569) in the path of pursuing a goal. Accommodation is the "active human strategy of response to resistance" (Pickering, 1995, p. 22), where in the face of obstacles, one devises "some other tentative approach toward [the] goal" (Pickering 1993, p.569). Each strand of the mangle has components of resistance and accommodation seen in the participant's own team practices.

Pickering's view of resistance is seen as passive, a perspective that changes the discussion of the response to power in a Foucauldian sense. Negativity and passivity were seen as team members continued in behaviors that perpetuated dysfunction and remained as obstacles in realizing the goal of patient care. This appears as individualistic views of patient care tasks, withholding support of idealistic notions about being a team, expressing powerlessness in having an influence with administration, and remaining silent and non-confrontational in situations of power differentials and autocratic hierarchy; the enactment of people being unable to achieve the "intended capture of agency in practice" (Pickering, 1995, p.22). These dances of agency remained unfinished in the team, where "clout" was not universal, meaning that by reinforcing power-holders, they were expected to "dance" with the system to effect change. These power relationships and their impact on agency in healthcare have been discussed by others (Powell, 2013). Team members can actively employ strategies to acknowledge their agency as it intersects with systems in practice. Developing team competency is an additional task to personal competency in what Lingard describes as "collective competence" (Lingard, 2012, p. 67).

In the play we created, non-human agency failed to be “captured” (Pickering, 1995, p.17). The team members were motivated by patient care and safety yet allowed their behavior to be influenced by perceived roles. Mechanisms for clear communication were not fostered. Power was accorded to traditional holders. Processes for feedback, shared tasks and reflection were absent. Human agency was not decentred in a way that invites balanced agency, but actually the non-human healthcare system machine held the team to a belief of powerlessness in finding system alignment with their goals of teamwork and patient care.

During the theatre process to imagine different ways of being a team, participants could address means to identify power structures and recognize how team members understand power. Is power claimed or abdicated? How, and by whom? Is this an influence of structured hierarchy or organizational systems that follow reportable areas of responsibility? Individuals may be choosing individualistic practices within a team organizational structure due to lack of training in team processes and functions.

The mangle is “shorthand” of the interaction of resistance and accommodation (Pickering, 1995, p. 23), the emergent “intertwined delineation and reconfiguration of machinic (sic) captures and human intentions, practices and so on” (p. 23). There is a reconfiguration of one aspect of practice in the discoveries made changing the scene of the team meeting. The physical re-arrangement of team meeting space required the team members to think differently about the interactions of each other.

Limitations and future research

Participation was limited to a small number of healthcare team members. While there was diversity in the group, other strands may become visible with different compositions of participants. All of the participants in this study were from acute care with specialized teams. Future inquiry with teams from other settings, such as those practicing in primary care, is

important. Including patients or clients and families in being fully present on their healthcare team brings further complexity that invites exploration.

Performative methodology is an innovative approach to interprofessional health research. Theatre opens up improvisation and imagination to consider ways of being in a team. Applied theatre methods with a skilled facilitator offer such possibilities. Future research that is embedded in practice may expose other strands of practice. Pickering's work bears relevance to healthcare practice and needs further exploration (Jackson, 2013), particularly with regard to the concepts of resistance and accommodation. Intervention research is needed to explore ways to teach (Frenk, et al., 2010), strengthen and support healthcare practitioners in interprofessionalism as it is intentionally expanded. Tying team effectiveness to other outcome measures requires a clearer view of the factors influencing team performance and performativity.

Performativity develops over time and calls for more longitudinal work. Further inquiry that situates performativity within professional identity discourses, including team identity, is needed. Fenwick (2014) also points to the increasing need to attend to the socio-material world of health care teams and their impact.

Conclusion

Performative research using forum theatre methods provided insight into aspects of being a team by making space for healthcare team member participants to enact their experiences of teamwork. In this study, interprofessional practice comprises complex relational elements. Practice components are seen as strands within a mangling of organizational influences that include administrative structures and power differentials, the means of accomplishing tasks individually and as a team, and having an orientation towards care as a common aim of team members. Understanding the agency of both humans and non-humans,

which in teamwork can be systems and technology, opens new avenues for conversations about interprofessionality and healthcare teams.

In achieving teamwork, the democratic principles of power distribution need to be resolved given the hierarchal nature of healthcare. Teams that intentionally examine performativity may guard against inflated emphasis on individualism in achieving collective and ethical team practices. As healthcare team members acknowledge and examine performances, team performativity is shaped. Participants in this study discovered that authentic enactment of being a team meant *acting* as a team rather than being *named* a team. Exploring the performativity of interprofessional teams through a performative methodology provides spaces to clarify the contexts of practice at the intersections of humans and systems, engaging with strands from the mangles *in* practice.

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Chapter 6: Reflections

"When does a session of The Theatre of the Oppressed end? Never – since the objective is not to close a cycle, to generate a catharsis, or to end a development. On the contrary, its objective is to encourage autonomous activity, to set a process in motion, to stimulate transformative creativity, to change spectators into protagonists. And it is precisely for these reasons that the Theatre of the Oppressed should be the initiator of changes the culmination of which is not the aesthetic phenomenon but real life." Augusto Boal (1992, p. 245)

In this final chapter, I discuss the significance of my study by returning to the story that began this dissertation and linking my findings to existing literature. The story describes the context of some of my first purposeful wonderings about how healthcare providers described their involvement with other healthcare providers and with me. As a patient and family member, I wanted a *we* to care, yet I did not know what a *we* meant.

This research has uncovered aspects of what a *we* means in the reality of being in a team for the participants in this study. Some of the findings reminded me of the attributes of nurses that I admire. Some of the findings gave me a feeling of bewilderment that explosions of knowledge and technology still leave us with confusion about what makes a *we* in healthcare. This notion of being together in a *we* is not merely theoretical, it really matters in a material way. Actually, while operating as a team may be seen as "just highly desirable" by healthcare providers, to patients, teamwork is "a basic prerequisite they often assume to be in place" (Clements, Dault, & Priest, 2007, p. 27).

Considering the perspectives gained through this research, I conclude by looking forward to future practice and research possibilities. I imagine how interprofessionalism might develop with new awareness and knowledge about performativity and the performance of team members and the team itself.

As I return to the beginning of my work through reflection, I am reminded of my earlier questions, "What is the relational work of healthcare teams that influence team performance?

How do healthcare providers understand teamwork? Which tensions in working as a team are difficult to talk about? How are tensions resolved? Maintained? What is at stake?" Similar questions have been raised about relational norms in healthcare teams (Amundson, 2005), discursive patterns of teams (Kvarnstrom & Cedersund, 2006), status and identity tensions in nursing roles (Apker, Propp & Zabava Ford, 2007), the challenges of teams (Grumback & Bodenheimer, 2004), and the potential of relational approaches to healthcare reform through networks and social capital considerations (Scott & Hofmeyer, (2007).

I realized very early in the process of discovering my research question about interprofessional (IP) team workings that it was a question of performance. What I did not know was that I would discover that performativity was both phenomena and methodology. Performative methodology as a means to explore team interactions brought with it methods that placed me on the edge of innovative research practices. Needing more knowledge, I extended my base through coursework in performance studies, arts-based research, drama, discourse analysis and critical thought, adding to my knowledge of nursing theory and philosophy. The challenge was to align the research question with methods that could be accepted in a culture that was heavily influenced by positivism where hierarchies relating to types of evidence can influence the value of knowledge emerging from findings.

Exploring relational questions of interprofessional pointed to performance methods. Applied theatre, specifically forum theatre, introduced me to the brilliance of Boal (1985), and the possibilities that come with performance. I wanted to co-create understandings with those living in the world of interprofessionalism. The challenges of teams may be documented, but the performativity of teamwork is under-appreciated.

This became my focus. How is *we* performed? Performativity was identified in my research as having a bearing on how teams perform and how teamwork is enacted. Forum theatre methods allowed practitioners in my study to question and challenge power structures,

traditions and obstacles to teamwork, looking for new ways to imagine being a team. I found that interprofessional practice comprises complex relational elements. Practice components of interprofessional teams can be seen as strands within a mangling of human and non-human forces that shape team performativity.

Performative methodologies are seen as innovative approaches to exploring research questions in healthcare. Using forum theatre methods in this project suggested to me that while my topic and method were intriguing to many, having participants come forward to engage in the theatre process was challenging. Some might have been reticent to participate because of feeling uncomfortable with the exposure and vulnerability that the stage may bring. Or perhaps other methodological factors were at play. Yet, the usual reasons offered by potentially interested team members unable to join the study were related to time and committing to a full-day forum theatre workshop.

Those who became participants came to the workshop ready to work. They had been thoughtful in preparing their ideas, and brought passion and opinion into the theatre. This is where the safety of the stage offered these people a place to play with their ideas, frustrations, experiences, emotions, insecurities and hopes for change. For the participants, when stories grew from “my” story to “our” story and the characters evolved into composites of self and colleagues, further understandings were realized (Diamond, 2007). Knowledge was created as I understood things in another way adding to my current understanding of teams, and the participants found reason and new meaning in their own stories.

I realized the power and magic of theatre to imagine things differently. I saw the emotion of members of a community (healthcare teams) as they struggled with their reality while looking for it to be different. As Diamond (2007) explains about forum theatre, “We are never telling any one person’s story, but rather creating the best fictional art we can that tells the true story of the living community … Characters have become community members engaged in various

struggles with each other and with dysfunction, which is sometimes personal and sometimes systemic" (p. 43).

In this study, such struggles became recognizable as performativity, having an influence on how team members behave in teams and think about the team itself. It also has a bearing on how the team is positioned in the larger frames of healthcare systems. The focus of this chapter is on relational practices, enacting teams, implications for practice from the research, suggestions for further research, limitations of this study and looking forward in my work.

Relational Practices

Performativity

As mentioned above, I started exploring the concept of performativity early in my studies. I have since come to appreciate that performativity is multi-faceted phenomena[49] and a methodological concept. The discussions of performativity as it exists in healthcare are scarce in healthcare literature. What has been discussed is a link between performance and various outcome measures, most instruments found lacking comprehensive, healthcare team specific assessment (Zeiss, A.M., 2002). In my work, performativity is linked to team engagement, culture and processes. The concept of performativity discussed in the context of healthcare is partly due to performativity's evolution outside of the science disciplines and may also be attributed to the fact that performative theory is relatively new. It is also a concept that is not easily grasped.

Conversations about interprofessionalism will remain superficial unless the performativity of healthcare can be examined and becomes a point of dialogue. Responses by participants in

[49] I intentionally use the plural *phenomena* in this case to suggest that performativity has multiple forms that comprise several components. Each of these components may be seen as a performance, speech act or other phenomenon within performativity. This position is shared by others, for example describing "the range of phenomena covered by the label 'performativity'…" (Veschueren, 1995 p. 300).

my study, such as, "…they had what they called an open forum but no one could talk and one person asked a question and got shot down right away," continuously reminded me of the importance to attend to performativity. This research demonstrated that performativity is hampered where the concepts of individual or collective performance and performativity are ill-defined or misunderstood (Sommerfeldt, Caine & Molzahn, in review).

Further questions remain: What influences the repeated performances of disengaged healthcare professionals? How does power become distributed? Are roles constructed for team members based on ability or stereotype? What rituals shape the healthcare culture? How does language, innuendo, jargon and silence factor into communication patterns and performances? How are others regarded in team work? In task work? What structures influence the responses of people in healthcare, practitioners and patients alike?

Resistance and accommodation

Closely related to concepts of human performativity is the acknowledgement of resistance and accommodation with non-human influences[50]. This may be seen as the *mangle* according to Pickering (1995; Pickering & Guzik, 2008) and associated with sociomateriality[51] as described by Fenwick (2014). Practices and mangles are of particular interest given the intentional spread of interprofessional team practices in healthcare reform in Canada. Relational interaction of team members with structures, technology, and performativity became an evident struggle for the participants and one that was often framed in a social context only.

[50] See Chapter 5 for a discussion about resistance and accommodation as Pickering (1985) uses it.

[51] Sociomateriality is a description of social and material entanglement. Fenwick (2014) contends that "social and material forces, culture, nature and technology are enmeshed in everyday practice. Objects and humans act upon one another in ways that mutually transform their characteristics and activities" (p. 44). As it relates to medical practice, Fenwick (2014) suggests that sociomateriality considerations have particular importance in gaining insight into medical practices and protocols where "things and possibilities are continually brought into being and into relationships" (p. 49) with the purpose of shifting the learning in practice from "acquiring knowledge to participating more wisely in situations" (p.44) through learning how to attune to minor material fluctuations and surprises, the "intra-actions" of others, and to find solutions.

When communication or assertiveness is stripped from the performativity of the practice environment, skills and tasks take on an exaggerated importance in team function.

Borrowing from Christensen's writings about organizational change, interprofessionalism is a disruptive innovation in healthcare (Christensen, Grossman, & Hwang, 2009). Transitional change within professional practices can be seen as a "problem to be resolved or managed" in contrast to the "notion of journey or pathway" (Fenwick, 2013, p. 362). The idea of change and learning as journeys requires movement to new places, or examination of familiar places from different angles.

While developing the theatre play, participants began to unbox feelings and ideas about being in a team that had few other avenues for expression. One participant communicated something that she had "been waiting 16 years to say," finding the theatre a safe and open place, free of protocols and engrained responses. The processes of forum theatre created room to challenge power, improvise and rehearse new things to say and places to stand in relation to another. The environment generated through these processes invited thoughts and emotions to develop in deeper ways. There seemed to be an irony that patterns of behaving in a team could be different if small attention was paid to the everyday or to an orientation to care (Sommerfeldt, in review). In the end, a small gesture of invitation to join, to engage differently, interrupted the patterns of disconnection.

The disconnections are obstacles; resistance in realizing a goal of the team. Structures, traditions, protocols are non-human "things" that have an influence on the actions and attitudes of people. Even the designation of "team" becomes a "thing." A "thing" is an entity, acknowledging materiality. The interaction of people and non-human entities is described by Fenwick (2014) as "sociomateriality." Understanding dimensions of *team* work, distinct from *task* work (Fisher, 2013), emphasises that "materials – things that matter" (Fenwick, 2014, p. 45) cannot be ignored in learning how to be a healthcare team. For accommodation to take

place, obstacles of resistance need to be appreciated as material agents and not simply the by-products of human activity.

When influences such as a culture of stereotyped hierarchy are seen as a material barrier to restructuring practices, it is tempting to default to a social understanding of how people should interact and behave. Acknowledging structural power as a "thing" offers pragmatic avenues for strategic innovation, one of several possibilities for accommodation.

Social capital

By leveraging the social power given to healthcare professionals, seen as among the most trusted professionals (Ipsos Reid, 2012), team voices have the potential to shape healthcare policies and protocols that support interprofessionalism, in contrast to those that are counter-productive, binding team members to negative performances. Viswanath (2008) suggests that communication is potentially one explanation that links social capital to health outcomes. The interprofessional competency of *communication* is described in the Canadian interprofessional framework (Canadian Interprofessional Health Collaborative [CIHC], 2010). While communication is a key interprofessional competency, the participants pointed out that communication styles were often linked to power and noted the necessity to focus beyond simple communication skills.

Social capital is viewed as a resource involving such dimensions as reciprocity, consensus, cohesion, obligations and trust in relationships, either person-to-person or person-to-organization (Viswanath, 2008). The inter-personal aspects of social power relate not only to the relational interactions of healthcare team members, but also as teams interface with patients.

When the tasks of the team fit the structures, teamwork can flourish distinguishing a "real" team from a "pseudo" team (West & Lyubovnikova, 2013). West (2012) compares creation of team structures without a clear task with the notion of "setting a table for guests

without preparing the food" (p. 29). In my research, I listened to participants discuss situations where a physician claims leadership on the team and becomes the "face" of the team, yet the other team members carry out the team tasks operating as a "team-within-a-team," disengaged from the physician. Further inquiry is needed to determine the dynamics of pseudo-teams and whether the workings of smaller groups are actually an aspect of establishing *networks* rather than sub or pseudo teams.

Taylor discusses the need to establish networks in primary care as a form of utilizing social capital to enhance "clinical working practice, enable professional growth and development and provide opportunities to influence outwards" (Taylor, 2013, p. 34). Several of the approaches to networking that Taylor identifies such as face-to-face interaction, telephone, internet, email, video-conferencing and social media, mesh with elements of interprofessionalism that could clarify the definition of *team*. Each of these ways of interfacing can either enhance or diminish team work. For example, participants in my study discussed the role of group email lists in establishing who is *in* and who is *out* of the team. Defining team membership was a particular issue facing the participants and their teams.

Differentiating the various understandings of team or network may perhaps involve identifying some other descriptor of practice, such as calling a type of coordinated practice a *group* or a *matrix* rather using the term *team*. Perhaps there would be fewer assumptions by patients and families about how healthcare or medical care is occurring if the word *team* is not invoked to describe other forms of inter-provider contacts. While this research was entrenched in performance, the semiotic representations of language play an obvious and significant role in human interaction and have an influence in the performativity of a team and how teams are enacted.

Enacting Teams

How healthcare providers enact *team* remains a challenge. Tremblay et al. (2010) describe a proposed nursing study offering evidence about research translation in an interprofessional collaborative cancer team practice. They note that the gap between practice and evidence is wide, "well-documented and troubling" (Tremblay et al., 2010, p. 2). The responsibility for collaborative ways of providing care seems to be "everybody's, but nobody's problem, too" (Thornhill, Dault, & Clements, 2008, p. 15)

One participant in my study described a "good" team as one where each member has confidence in one's own abilities and knowingly trusts the abilities of the others. Understanding one's own professional scope of practice and identity, as well as being able to articulate it to others can strengthen rather than erode professional identity and influence how the team functions. McNeil, Mitchell and Parker (2013) demonstrate that a key cause of failure in interprofessional practice can be traced to interprofessional conflicts based on threats and challenges to professional identity. They suggest that "professional identity faultlines" (p. 291) can appear, impairing team functioning. Similarly, this was observed in this research and expressed in statements of participants such as, "[As] the team continues to evolve, I think sometimes there's been lots of tensions … There's been a few instances where I don't think nurses truly understand our role" (M. interview).

At macro and micro levels, status, privileges or simply "tacit behavioral norms" (McNeil et al., 2013, p. 293) have a bearing on the narratives brought into teams. Socially accorded power would need to be intentionally addressed and somewhat divested to eliminate the threat of what is seen as "immunity" to some practitioners. To participants in this study, the challenges of autonomy in practice as opposed to employment contracts, got in the way of having shared vulnerabilities in practice. For these participants, nurses believed that any disruptions could threaten their jobs, yet a physician has no such risk.

Some participants explained that it was satisfying to be part of a team that came together almost “organically” rather than from a top-down requirement. Personalities seemed to play a greater role and also carried the greatest risk for failure. A participant explained that these kinds of experiences pointed out the fundamental need to have formal and informal processes that focused specifically on team functions, structures and aims. It seemed important for many of the participants in this study that their team becomes established as an *authentic* team where they are performing as a team, rather than just being named a team. They needed processes and support to actually *be* a team.

This concept of *being* a team speaks directly to performativity. Where the contributing aspects of a team’s performativity are not attended to in depth, there is a risk that the observable challenges to teamwork will be noticed and addressed in a superficial way. One example of this is team members being aware of communication difficulties and addressing them through a simple approach of teaching communication skills. Alone, this is a shallow attempt that avoids examining unspoken practices, limiting the consideration of power structures, the role of rituals, perceptions of consequences, fairness, openness and processes that might encourage disclosure and frank discussion. The usual language of a team and how silence is understood or used may be factors in giving or receiving the messages and implied meanings in discourses. Without intentionally attending to enacted ways of being in a team, it is tempting to default to skill-based mechanisms rather than aiming for competency in shared clinical judgment that involves ensuring shared understandings (Lingard, 2012).

Implications for Practice

Interprofessional education

Ensuring teamwork capabilities of healthcare providers leads to considerations about how to effectively educate people for interprofessional practices. Having used theatre methods

to explore and co-create knowledge, my approach to teaching interprofessional education (IPE) is changing. Fenwick and Edwards (2013) detail ways in which performative ontologies, as opposed to more usual representational epistemology, "de-couple learning and knowledge production" (p.61) by decentering human agency and considering the relational ties to sociomateriality in learning.

The concept of responsive agencies, both human and non-human (Pickering, 1995), is now a consideration in my own views about learning that involves interprofessionalism. For example, the "webs of entangled human/non-human actions, matters and meanings" (Fenwick & Edwards, p. 54) that contributes to boundary-making and boundary-marking as students from different faculties come together needs attention. The inherent prejudices and a priori social positioning of professions not only presents social awkwardness on student teams, it may influence the perception of authenticity of interprofessional course content and the structures or experiences intended to invite interprofessional learning. How university faculties reinforce or challenge the social position of their own profession becomes a filter in the congruence of interprofessional elements and professional components of their education in this example.

Curricula for health sciences students include interprofessionalism, since in many professions, it is a requirement in the push for accreditation (Curran, Fleet, & Deacon, 2006). The Canadian interprofessional framework (CIHC, 2010) identifies and explains competencies to be developed for interprofessional practice, and many post-secondary educational institutions are intentionally expanding efforts to provide IPE, in varying degrees to health sciences students in Canada. The challenge of students carrying forward the attitudes and behaviors to foster or maintain interprofessional in their practices following licensure remains. Clements, Dault and Priest (2007) state that the greatest obstacle to expanding interprofessionalism is "the hierarchical culture of healthcare" (p. 31). This social construction of how healthcare should function is at odds with the democratic nature of effective teams where leadership might be

shared. Funding models, concerns about malpractice, time constraints and the lack of communicated successes are seen as barriers to interprofessional practice (Clements et al., 2007).

Interprofessionality is dependent on views and behaviors that call on phenomena within performativity. Barad (2003) explains that all bodies "matter" (a play on words considering materiality) through "iterative intra-activity," the "world's… performativity" (p. 823). Teaching, learning and involving students in discovery, is a dimension of shared knowing where understandings and making sense of practices are relational. Barad (2003) reminds me of remaining "resolutely accountable for the role 'we' play in the intertwined practices of knowing and becoming" (p. 812).

This research highlighted implications for IPE to be authentic and practice relevant not only for students, but for healthcare practitioners as well. Consistent elements and language from educational and practice institutions that align with frameworks developed through cooperation and collaboration, such as the Canadian Interprofessional Health Collaborative (2010) can guide interprofessional learning and initiatives. The participants in this study expressed desires to have individual and team capacities to meet patient needs in a more collaborative and integrated way of practicing. The often-expressed pessimism of imagining or recognizing change in the systems in which they work was frequently accompanied with a hope for improvement in team processes and new ways of being a team. The learning that can realize such a transition includes the intentional acknowledgement of the presence of non-human influences and human strategies in building team work and accomplishing team tasks.

Nursing practice and education

Having ways of checking on the *we* is inherent in being a team. Developing an atmosphere that invites feedback and reflection is part of team membership. Fostering this is a nursing leadership opportunity. Front-line nurses demonstrate leadership by cultivating trusting

relationships with team members where communication is clear and helpful, free of hidden agendas and silences. To do this, leadership development programs can be seen as a strategy for nurses to actively lead in change management initiatives (MacPhee & Suryaprakash, 2012). Administrators can become more knowledgeable about the workings of interprofessionality and what is needed in way of mentorship and support to actualize the philosophical ideals of interprofessional collaboration, including focused attention to team development (Bajnok, Puddester, Macdonald, Archibald, & Kuhl, 2012). Other research also highlights a clear finding of my study that the participants felt disconnected from their facility or system administration. For instance, Bajnok et al. (2012) describe a situation of practitioners being "told to create a team yet were given no direction as to how to do this, no additional time for team development, and no resources," with nurses feeling the responsibility for the team having "little support to deal with scheduling challenges across the team, values differences, and power differentials" (p. 88).

Support of team development and maintenance is crucial for effective interprofessional teamwork. As interprofessional team practices are intentionally expanded, the known challenges of mandated teams need to be addressed as decisions and policies are being made. Nurses are encouraged to engage in political processes and develop ways to ensure the voice of nurses is raised in decision and policy making (International Council of Nurses, 2008). Without profound engagement, nurses may become extraneous in change processes and "mere spectators" (Salmela, Eriksson, & Fagerström, 2012, p. 696). The attributes of nurses who can provide leadership particularly in interprofessional teams extend not only to professional development, but also carry implications of curricula that promote rather than inhibit competency in welcoming innovation, negotiating power structures and developing relational qualities of leaders (Anonson et al., 2014).

Interprofessionalism is beginning to be embraced as an aspect of nursing knowledge, yet it faces political, professional and social pressures as cultures shift (Almas & Odegard, 2010; Braithwaite et al., 2013; Laurenson & Brocklehurst, 2011). Questions about professional identity have been a source of concern as scopes of practice overlap and administrative/organizational influences evolve. Evidence of structural, interpersonal and individual dynamics that have a bearing on how nurses and others can strengthen autonomy and skills to enhance, not threaten, interprofessional work in practices is emerging (Mitchell, Parker, & Giles, 2011; Mitchell, Parker, Giles, & Boyle, 2014; Sommerfeldt, 2013). In my work, this was evident in the points of struggle experienced by participants. These included struggles with structures in healthcare and teamwork, struggles of performance and competing attentions, and struggles within their own professional practices.

Of particular concern is ensuring that nursing curricula have embedded aspects of interprofessionalism, central to nursing identity, not only in theoretical components, but in clinical learning experiences to prepare students for expanding interprofessional practice environments (Aase, Aase, & Dieckmann, 2013). While engaged in this research, I listened to many stories of nurses wanting more skill and looking for flexible structures so that they could embrace interprofessionality as part of health sciences core knowledge. Participants from nursing, seeing a gap between what they imagined interprofessional interaction in their practice could be and what it actually is, described an ethical strain in making compromises to maintain appearances of being a team.

Some participants in my study raised questions about their ability to show vulnerabilities within their teams. Others talked about the moral and ethical distress of dysfunctional or disrespectful team behavior. Certain participants talked about the ethical questions of not including clients or patients in care decisions. Nurses have a distinctive position in interprofessional teams, as interactions with patients in the daily activities of their practices

provide a unique moral perspective (Wright & Brajtman, 2011). This study reinforces the call for nurses to consider influences within nursing practice and education that can further engage the profession in interprofessionalism.

Returning to performativity

Enacted knowing became apparent as I began to appreciate performativity as methodology. Realizing that *performance* was a term often associated with evaluating teams and individuals, I began my research journey by tying it to the *we* of healthcare teams. I began to realize that performance could not be assessed without considering the forces that shape performativity. Turning to performance-based methods, I recognized that forum theatre could offer spaces to explore deeply the political, spoken and unspoken, historical, socially constructed and professional (individual and organizational) forces that have an influence in interprofessionalism (Lingard, 2012; Price, Doucet, & Hall, 2014; Salhani & Coulter, 2009).

I have developed an acute awareness of observable team functioning in my everyday encounters with the health system. What started with Jas in my story which began this dissertation has continued with other family members as we interact with healthcare providers. There is little current literature related to just how patients and families interact with a team, particularly with the view of being part of that team in practical rather than theoretical ways. Howe (2006) asks if patients can be on the team to explore patient safety, suggesting that evaluating the impact needs to be found in clinical settings, not based on perceived satisfaction. Thompson (2007) suggests that the duty of interprofessionalism is to keep the patient and family as "the heart of the matter first," rather than maintaining a "contemporary buzz word" in modern healthcare (p. 562).

In deconstructing interprofessional collaborative practice, Thistlethwaite, Jackson and Moran (2013) propose that perhaps *continuity* of care is of particular importance in interprofessional environments. Specifically, informational continuity is necessary to achieve

collaboration with client centeredness. One of the clear findings in this research was that the way in which information was handled in a team had a bearing on how teamwork was understood, including defining the team by the distribution of information. If the management of information is a parameter in defining who is on the team, the implications of including patients are enormous.

While my research did not include patients, and this can be seen as a limitation of my study, several issues were raised for me. One issue was that while I realized that the client was not a character in the theatre play, the central focus of the interactions of the other characters was indeed, the client. Just as practitioners need training to be effective in team work, by implication, patients and clients also need interprofessional education in team functioning. The language of patient and client-centeredness brings complexity at the very least, and more worrisome, casual use may make the term functionally meaningless. The structures and traditions of healthcare interactions that are embedded in the delivery system are factors that provide stability and predictability in accomplishing the task of healthcare provision, yet create practice environments where providers become resistant to envisioning alternatives.

The participants in this research echoed the challenge that hierarchal influences and power variances lead them to have difficulty imagining how their practices might be different. In the forum theatre workshop, they tried out a new and simple relational approach to challenge disengagement rooted in historical power structures. It was interesting that while they spoke about needing to establish trust in the other members of the team which only develops over time, in the play they chose to use a new team member as a catalyst for change. Perhaps this speaks to a hesitancy to be change agent on their own.

Limitations

A limitation of my study is excluding patients. The decision to have inclusion criteria of participants being a healthcare practitioner in a current healthcare team was purposeful given the further complexities of patient involvement. Including patients in this research, while important in considering interprofessionalism, shifts the discourse between and among the healthcare providers. Varying degrees of patient involvement and the conceptual framework of the interprofessional practice (Boon, Verhof, O'Hara & Findlay, 2004) have an influence on the team makeup and were beyond the aims of this study.

One aspect of my research that I would approach in another way now that I understand performativity differently and appreciate the implications of resistance and accommodation is to locate my work in primary care practices. I now see that the barriers to accessing health care practitioners in primary care for this study was part of a disjointed and chaotic situation facing primary care reform in transition. What I assumed was gatekeeping may have actually been a reactive obstacle of individuals uncertain of their role in handling the request and without team processes to make my invitation to participate in the research to others. With strategic positioning, the resistance may have found accommodation. I failed to acknowledge the non-human choreography in the dance of agency occurring in the present primary care structural reframing.

In designing the study methods, I was sensitive to the time commitment required of the participants, balancing the time needed to effectively produce a forum theatre piece with what could be reasonably asked of participants. While the ideal participant group would have included another 3 to 5 participants, those who came were invested in their stories of healthcare and experiences of being in a team. The interviews during the weeks before the workshop provided the necessary groundwork for participants to think about their experiences, the meanings that come from team behaviors, some of the benefits of working in their team, some

of the challenges, and other features of team work in their practices. The interviews were crucial to provide information and perspectives that guided me and the theatre facilitator in structuring activities of the workshop. Ideally, the workshop would have provided for prolonged interaction of the participants to explore further strands found in the mangles of their interprofessional team practices.

Suggestions for Future Research

There are many questions raised in my research that remain. These include questions around measurement in primary care teams, forum theatre methods in healthcare research and developing interprofessional theory through deeper understanding of the concepts of resistance and accommodation in Pickering's theory of the mangle of practice (Pickering, 1995).

Measurement in primary care teams.

Practice sites of primary care teams are an ideal setting for further interprofessional team research. The teams are definable and in many cases mandated through remuneration arrangements. In primary care teams, the philosophical position of the client is central to outcome measures and the aim is teamwork whether the teams are operating as inter- or multi-disciplinary groups rather than interprofessional teams. Exploring how performativity has a bearing on team aspects of primary care, particularly in areas identified in other research, such as structural influences, role construction and boundaries (MacNaughton, Chreim, & Bourgeault, 2013), can inform approaches to measure or report in assessing team development and function.

Interprofessional frameworks are beginning to appear in the literature to describe and guide interprofessional practices. Such frameworks may also provide structures for accountability and measurement of team function. Tracking and measuring changes in care delivery and research translation is needed to assess the effectiveness of such structures.

Sibbald, Wathan and Kothari (2013) found that even though the trend toward team care is increasing, senior physicians are gatekeeping the flow of information and uptake of evidence and changes in practice. The need for tools to track and assess aspects of team interaction, such as collaboration, is a priority in Europe (Samuelson, Tedeschi, Aarendonk, Carmen, & Groenewegen, 2012) and in North America, as noted at the Canadian Association of Continuing Health Education (CACHE, 2013) and Collaborating Across Borders IV (CAB IV, 2013) conferences held in Vancouver, B.C. in June 2013.

Theory development.

Theorizing interprofessionality remains a pressing priority. Reeves and Hean (2013) point out that theory is pragmatic and inseparable from practice, noting that "the use of theory in the interprofessional world has evolved and matured" (p. 2) over the past decade. For nursing, Meleis (2012) suggests that the discipline of nursing has matured sufficiently to the point that "the future of the discipline lies in situation-specific theories" (p. 419). Situation-specific theories bring together the clinical realities and contexts of nursing practice, distinct from historical nursing theory in that it is developed from other theories, research, and practices. The idea of interprofessionalism in nursing as situation-specific theory resonates with the realities of team practices in that it is "more tolerant of multiple truths" (Meleis, 2012, p. 420).

Advancing interprofessional theory may involve further exploration of the concepts of resistance and accommodation. These concepts, explored in more depth in Chapter 5, open up ways to reconsider important elements in interprofessional practice including such things as sociomateriality. Describing the obstacles and the strategies for accommodation in interprofessional practices and the relationships between them may also help in the identification of possible outcomes of interprofessionalism. As the sociomateriality (Fenwick, 2014) of interprofessional practices becomes understood, the "dance of agency" (Pickering, 1995) between practice realities of team members and the structures, resources, or

performativity can inform both the theoretical and practical attempts to position practitioners and patients in the same team. The complexity involved in the interaction of people, health and systems invites participatory discourse when acknowledged in theory and in practice.

Methodological considerations

Forum theatre may be considered as intervention research with existing team practices. Together with a theatre artist facilitating, healthcare team members could work together to identify struggles, develop ways to transform conflict, find meaning and develop processes for dialogue in defining and achieving team success.

Further research is needed at multiple levels. Randomized clinical trials could be constructed that examine before and after interprofessional educational interventions in relation to measures of team outcomes. Ethnographic explorations of healthcare cultures in the interprofessional world and grounded theories of social processes in the transitions of system changes toward interprofessional practices can provide insight. The continued development of measurable outcomes of team performance and further exploration of pre- and post-licensure IPE may inform theory.

Looking Forward

My understanding of being a nurse in an interprofessional world has expanded to embrace new dimensions. The questions of the client/practitioner dynamic that brought me to my doctoral work linger in various forms. This research was about creating avenues for change. I wonder what would have been different if it had been possible for Jas and I to enter into the space of *we* in our early interactions with healthcare providers. How might the route have been different? Questions remain. I plan to join with others in continuing to explore the relational

aspects of interprofessionalism in becoming a *we.* Doing so calls practitioners and patients to attend to the performativity of healthcare teams.

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