The Darkside of Collaboration: A pilot study

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Short Header: The Darkside of Collaboration

ABSTRACT

It is commonly believed that collaboration enhances quality of life for both practicing professionals and for their clients (D'Amour & Oandasan, 2005). Hebert (2005) comments that "many of us are 'true believers' in interprofessional practice" (Herbert, 2005, p.3), suggesting that the voice of those who do not participate willingly in interprofessional collaboration activities is not well-represented in the interprofessional collaboration literature. This study examines the negative aspects of interprofessional collaboration as reported in a survey completed by students in rehabilitation medicine. The major reoccurring categories that emerged as deterrents to collaboration related to logistics, team function and the professionals involved. These superordinate categories are supported by the literature that explores the barriers to interprofessional collaboration, though some new subordinate categories within the categories emerged that were not prominent in the literature.

RATIONALE

The topic of interprofessional collaboration has bombarded the Health Sciences professions. According to Ho (2008), interprofessional collaboration is "fundamental to the very fabric of the careers of health professionals" (Ho, 2008, p.1). In recent years there has been a need for evidence that good collaboration benefits patients, clients and professionals (Horder, 2004). It is commonly believed that when collaboration is good, everyone is content and work is done efficiently with the utmost care. When collaboration is successful the members of the team support it and the patients benefit (Head, 2002).

Much of the literature in interprofessional collaboration has focused on the process of implementing interprofessional initiatives (Cook, 2005), while a smaller literature has examined factors that support or interfere with interprofessional collaboration (Atkinson, et al., 2005 and Kvarnstrom, 2008). A major barrier in interprofessional collaboration is the assumption that people want to collaborate. It is likely that the voice of individuals who do not participate in interprofessional collaboration activities is not well represented in the literature as many people are strong supporters of interprofessional practice (Herbert, 2005).

What is Collaboration?

According to Health Canada, collaborative patient-centred practice encompasses a multidimensional approach to patient care. Collaborative patient-centred practice contributes to:

> …improved population health / patient care; improved access to health care; improved recruitment and retention of health care providers; improved patient safety and communication among health care providers; more efficient and effective employment of health human resources; and improved satisfaction among patients and health care providers. (Health Canada, 2010)

Labels for Collaborative Efforts

Many researchers draw a distinction between the various labels applied to collaboration. Most authors view the differences as deterministic in nature and concern themselves with only one label, either multidisciplinary, interdisciplinary or transdisciplinary collaboration. According to Kilgore and Langford (2009) the three labels should be viewed

along a continuum based upon the degree of interaction between the various professionals on the health care team. This view is supported by Hall and Weaver (2001) as well,

> …health care teams function somewhere along a continuum of degrees of interaction among team members and their degrees of responsibility for patient care. Different points on this continuum are represented by the multidisciplinary team, the interdisciplinary team and the transdisciplinary team. (Hall & Weaver, 2001, p.868)

In a multidisciplinary approach members of the health care team work alongside one another; each providing and applying knowledge from their respective disciplines to the patient with virtually no knowledge or interaction with the other team members involved. Interdisciplinary collaboration involves a higher degree of interaction among the health care team members compared to the multidisciplinary approach. In interdisciplinary collaboration members of the health care team work together towards a communal goal, thus increasing the need to interact with other team members in order to coordinate their discipline specific contributions while addressing the common goal(s) of the team. Transdisciplinary collaboration involves the highest degree of interaction among the professionals on the health care team; members from the specific disciplines are knowledgeable about the roles of the other professionals and are able to fulfill some functions that "are traditionally performed by another discipline" (Kilgore & Langford, 2009 ,p. 2). Kilgore and Langford (2009) refer to this phenomenon as blurring of the roles. Often these terms are used interchangeably and overlap. The definition provided by Kilgore and Langford (2009) allows all of these interactions involve collaboration in a professional workplace. As such, much of the research using the terms 'interdisciplinary', 'trandisciplinary' and 'multidisciplinary' also relates to aspects of interprofessional

collaboration. When identifying previous literature in relation to 'interprofessional collaboration', literature containing any of the above terms was considered as potentially involving interprofessional collaboration.

Operational Definition of Interprofessional Collaboration

For the purposes of the current study the cover term 'interprofessional collaboration' was used to be inclusive of all collaborative efforts between professionals, and was defined as the "development of a cohesive practice between professionals from different disciplines" (D'Amour & Oandasan, 2005, p.9).

PURPOSE

This study was intended to fill a gap in the collaboration literature. Interprofessional collaboration could not be successful if it did not have some support from the majority of team members. Rehabilitation medicine professionals would be expected to support and participate in collaboration in both medical and educational settings. The findings of this study sought to improve interprofessional collaboration initiatives and interprofessional education. Addressing and acknowledging the opinions of people that do not support collaboration could potentially aide in maintaining a strong team dynamic.

The purpose of the survey was to answer the question "What are the negative opinions regarding interprofessional collaboration?" This was achieved through collecting information regarding reasons why the participants disliked interprofessional collaboration, what they saw as problems with interprofessional collaboration and what would discourage them from being involved in interprofessional collaboration.

METHOD

Participants

Participation in the survey was voluntary and administered to first year students in the Faculty of Rehabilitation Medicine approximately one month into their first clinical practicum placement. There were 60 persons registered in the class and 50 surveys were returned. Only students who attended the lecture that day were given an opportunity to complete the survey. Students were not told in advance that a survey was going to be administered.

Materials

The survey consisted of six question and basic demographic information that included age range, sex and membership to a specific discipline of rehabilitation medicine as the survey had potential to be administered to speech-language pathology, occupational therapy and physiotherapy students. The survey was administered in paper form and could be filled out with a pen or pencil. All questions, excluding the demographic information, required a short written response. The first two questions were intended to collect background information on whether the participant had training or experience in interprofessional collaboration and gave the participant an opportunity to briefly explain. These were followed by four questions regarding the participants' personal opinions around interprofessional collaboration (see Appendix A).

Procedure

The survey was administered at the end of a lecture. Forms, including an explanation of the research project, survey and prize draw entry, were handed out to the students and students were instructed that the survey and prize draw (for a $25 gift card) were optional. The

survey administrator stayed outside the room for 10 minutes while the students who chose to participate completed the form and returned at the end to collect the boxes.

The answers from the survey were transcribed and inputted into Atlas.ti. (6.0.14, 1993-2011), a qualitative data analysis software program. The data was then analyzed for reoccurring themes using key word searches and multiple systematic readings for reoccurring themes that may not have been identified by key word searches. These themes were then coded into general categories. The data was sorted into subordinate and superordinate categories.

The survey questions pertaining to experience and training were analyzed separately from the questions relating to the negative aspects of interprofessional collaboration. The training and experience questions were used to form a general understanding of the group's previous knowledge and experience of interprofessional collaboration. Demographic information was analyzed independently to determine the overall understanding regarding and exposure to interprofessional collaboration. The main questions were analyzed collectively, as opposed to individually, as the underlying theme of all questions was to discover the negative aspects or opinions in relation to interprofessional collaboration.

RESULTS AND DISCUSSION

The superordinate categories included: logistics, team function and professional as overarching categories. The subordinate categories encompassed under 'logistics' were 'time' and 'scheduling'. 'Team function' included 'dynamics', 'ideas/approaches', 'flexibility', 'personality' and 'productivity'. 'Professional' included 'occupational role' and 'skills/knowledge'.

Out of the 50 participants who completed the survey, 37 had previous experience in interprofessional collaboration and 13 did not have experience. The rehabilitation medicine classes had a mandatory interdisciplinary (InterD) training module at the beginning of the program which included collaborating on a hypothetical client with students from other rehabilitation medicine departments. Participants who had experience in interprofessional collaboration sited the InterD module, volunteer or paid work experience as where they took part in or observed interprofessional collaboration.

Out of 50 participants, 39 reported having training in interprofessional collaboration. The majority of participants considered the Interdisciplinary (InterD) module as training while fewer had formal training at a previous work or volunteer placement. Eleven participants did not have training in interprofessional collaboration. Whether the participants with no training, did not attend, or did not consider the InterD module as interprofessional collaboration is unknown.

Logistics of Interprofessional Collaboration

The category of 'logistics' included the processes of interprofessional collaboration that surround the formulating and implementing of interprofessional collaboration that is external to individual beliefs and personality. 'Logistics' can be viewed as the administrative aspects of interprofessional collaboration that can interfere with the ability of individuals to participate or for interprofessional collaboration efforts to be productive.

'Logistics' included the subordinate categories of 'time' and 'scheduling' (see Figure 1). Taking part in interprofessional collaboration was described by one participant as being "time

consuming" and as a discouraging factor for taking part in interprofessional collaboration "if it meant a lot of extra time commitment."

Conn et al. (2009) observed time as a constraint for interprofessional collaboration with nurses complaining about the lack of time allotted in their daily schedule to take part in collaborative efforts. In relation to size of caseload, not having time to talk to one another also presented as a monumental challenge of interprofessional collaboration. Excessive amounts of time can also be spent collaborating and time with the patients is limited, so a rapport may not be built with the client (Parker Oliver & Peck, 2006). This implies that people are using too much time in the collaboration process and not enough time implementing the treatment and building a professional relationship with the client. This theme emerged in the participants responses, but was likely not as prominent as the participants are students and had only began their first clinical practicum within the program that involved building rapport with clients.

Difficulty in scheduling meetings was also a reoccurring response by the participants. One respondent commented that it is "very difficult to coordinate schedules to be able to meet and collaborate effectively." Another participant wrote that "it is impossible to find a time to meet that works for everyone".

Øvretveit (1997) identified "danger of too many multidisciplinary meetings" (p.74) as a possible disadvantage. The possibility of too many meetings involving multiple participants could decrease the amount of time being spent directly with the client. This implies that the potential for too many meetings as well as difficulty scheduling the meetings act as a deterrent from participating in interprofessional collaboration. The inability to schedule meetings or excessive amounts of meetings could also serve as a barrier to interprofessional collaboration,

with professionals being willing to participate, but not having time allotted to meetings or not having enough time to dedicate to patients.

Team Function in Interprofessional Collaboration

'Team function' relates to the personal and group differences that can interfere with interprofessional collaboration. These factors influence the ability of interprofessional collaboration to be productive and often involve situations that create emotional conflict brought about by personal differences or opinions.

'Team function' included the subordinate categories of 'dynamics', 'ideas/approaches', 'flexibility', 'personality' and 'productivity'. All of these categories directly or indirectly affect the ability of individuals or the interprofessional team as a whole to collaborate (See Figure 2).

Dynamics. How the group functioned based on dynamics was identified by multiple participants as a negative component of interprofessional collaboration. One respondent directly stated "poor group dynamics" as a negative aspect of interprofessional collaboration. Another respondent specified that interprofessional collaboration "involves trust that other members of the team will do/follow through". This implies that trust between group members does not always exist and when absent proves to challenge interprofessional collaboration.

Ideas/Approaches. Individuals in a group having markedly differing opinions or approaches to treatment also emerged as a subordinate theme. One respondent stated that, "opinions for treatment may clash". Another participant wrote that a discouraging factor in interprofessional collaboration is "when the group's vision or therapy style doesn't match or conflicts strongly with mine". Further investigation would be needed to determine more

specifically how differing opinions and ideas act as discouraging factors for participation in interprofessional collaboration.

Flexibility. Flexibility can be qualified as an ability to accept other team members ideas and integrate the idea into the whole picture; this sometimes involves letting go of one's own opinion for the greater good of the team. "Some people do not have the ability to be a team player or to collaborate…it's their way or the highway", commented one participant. Another respondent noted that individuals who were "particularly opinionated" and who were "not valuing other's opinions" as negative aspects of interprofessional collaboration. A different participant also wrote that having to give up some ideas to go with the group's ideas as a disadvantage of interprofessional collaboration. Øvretveit et al (1997) and Schein's (1992) theories argue that for teams to collaborate effectively they require self-analysis, empathy and flexibility, which does not usually happen spontaneously but requires direction, support in a safe environment (Dawson, 2007). This indicates that individuals without the ability to be flexible within a group dynamic would not collaborate effectively in a group environment, providing a challenge to the other members of the team.

Productivity. The productivity of a collaborative team is based on how efficiently a group decision can be formed within a reasonable period of time. This was identified as a reason why some participants did not want to engage in interprofessional activities. A participant reported "decisions in a team setting can be overanalyzed to the point where the team is no longer making an efficient use of time and resources." Massey (2001), when referring to negative aspects of interdisciplinary and multidisciplinary collaboration, wrote that they both involved a "fragmented, incomplete assessment, conflicting priorities and strategies,

lack of a systematic and holistic approach and inefficient, expensive outcome attainment" (p.86). Massey's statement could imply that collaboration is not always productive.

Personality. Based on the review of literature, 'personality' was an expected theme to emerge out of the participants responses as it is a source of conflict in workplace settings in general and is not exclusive to the healthcare profession. The participants reported "different personality types" including specific types of personalities including "difficult", "rigid", and "opinionated people" as problems with interprofessional collaboration. This is consistent with Parker Oliver's (2006) observation that, "personality conflicts" (p.12) are a barrier to interprofessional collaboration. The participants did not define 'personality conflicts', but some behavioral traits were listed by participants. Self-disclosure and respect for individual personality types is essential in avoiding the personality clashes that can arise within interprofessional teams (Head, 2002). Team members must be prepared to address members who "fail to pull their own weight", "dominate meetings", "are uncooperative" and "refuse to share information" and are "unwilling to be honest with peers and address conflict"(Head, 2002, p.337)

Professionals in Interprofessional Collaboration

Professional issues in interprofessional collaboration related directly to the professional as defined by his or her training and the problems that arise from differences in their occupational identities, skills and/or knowledge. These subordinate categories can overlap as occupational roles are often directly taught as part of the skills and/or knowledge that give an individual qualification to be a professional. These vary between individuals, so remained in two

separate, but overlapping subordinate categories of occupational role and skills/knowledge (see Figure 2).

Occupational Role. Occupational Role, including self-perspective and perspective of other's roles and ideas of inequality between professions emerged as a negative aspect of interprofessional collaboration. Comments such as "some professionals thinking they are superior to other disciplines/ their occupation has more clout" and "everybody wants to prove their specialty is the most important" emerged in the participants' responses. Inequality between occupation roles is supported by the interprofessional collaboration literature. One study involving occupational therapist, physiotherapists, social workers and nurses found an "inequality in levels of participation" (p.5) between different professionals (Atwal & Caldwell, 2005). This can take form as a hierarchal health care model where professionals who deal with physical dimensions of health care often supersede the psychosocial dimensions of care (Parker Oliver & Peck, 2006). The inequality or perception of inequality between occupation roles implies that some individuals who are devalued in their professional role would be less willing to participate.

Professional skills and knowledge vary between individuals belonging to the same team. This was identified as a cause of conflict between people on an interprofessional team. The comments surrounding knowledge could be best summarized by one participant writing "not knowing everybody's (or your own) role clearly" as being a problem with interprofessional collaboration. Disagreement regarding "ownership of some areas of practice" (p.27) was a cause of conflict for a multidisciplinary team given a collaborative project (Jones, 2006). This implies that individual members would have different concepts or their own and other's roles

on the team, showing a definite gap in knowledge regarding each other's and/or their own roles. A possible reason for this may be that individuals are trained with specific approaches and strategies that make up part of his or her occupational identity and those ideas are ingrained in what the professional believes is necessary to provide the best possible treatment. This indicates that not knowing one's own capabilities or the capabilities of other professionals within a team would impact collaboration.

Skill level becomes a negative aspect of interprofessional collaboration "when all team members aren't equally skilled" as one respondent commented. This implies that professionals not having full or adequate skills within their specific discipline, is a barrier to interprofessional collaboration. Skill level was not a prominent theme in the literature regarding interprofessional collaboration. The context and examples provided by the participants implied that the more skilled individuals in the team would be doing the majority of the work on the team, which may relate to inequality between professions based on the specific needs of clients. Atwal and Caldwell (2005) identified valuing one's own skill level as important for providing effective and efficient multidisciplinary team treatment, but did not address the skill level of other team members as a contributing factor. It is unclear whether the skill inequality noted by the participants was due to their specific occupational role, or due to personal factors enabling individuals from contributing their skills to the group.

CONCLUSION

The problems with interprofessional collaboration that were identified in this study generally reflected concerns that have been documented in the literature on interprofessional

collaboration. It is important to note the participants were not practicing professionals, but students being educated within the Health Sciences. Students, who are not yet licensed professionals and not yet working in a collaborative workplace, were able to identify multiple negative aspects for interprofessional collaboration. Student-based research can provide input on potential difficulties with interprofessional collaboration, but as mentioned previously does not directly reflect opinions of working professionals. This survey highlighted themes about aspects of collaboration that participants disliked and factors that discouraged participants from taking part in interprofessional collaboration. More research is needed to qualify the aspects of interprofessional collaboration that are disliked and how to prevent or solve these problems.

The survey questions were intended to guide participants to express the negative aspects about interprofessional collaboration. All participants who completed the survey were able to write at least one reason they would be discouraged from participating in interprofessional collaboration, even if they personally had not experienced a negative consequence or aversion to collaboration. This signals an even greater need for literature regarding the negative aspects of collaboration. Students, who likely have not worked directly in the profession they are training in, have already formed opinions regarding the negative aspects of interprofessional collaboration. Information that advances our understanding in the opinions of interprofessional collaboration can only help by acknowledging concerns of future professionals and address their concerns early on.

Limitations

Interprofessional collaboration was not clearly defined for the participants. Individuals, based on previous knowledge or experience, may have interpreted the working relationship differently. Through analysis of responses, the term 'interprofessional collaboration' could be equated with 'team work'; however, whether or not the comments referred to group work with individuals studying towards the same profession or referred to previous work or volunteer experience with people of different professions is unknown.

Though the survey was intended to be short answer, some participants answered questions with a single word e.g. "people" as being a problem with interprofessional collaboration. These types of answers had to be discounted when analyzing for categories as the context was unknown.

The time allotted for the survey was 10 minutes. An option of taking more time to return the survey was not given and this may have not allowed some participants to fully explain their responses. They also may not have had time to recall specific situations or experiences that may have been relevant when formulating responses regarding interprofessional collaboration. More time, or the option of taking the survey away and returning it later may have allowed more in-depth responses.

Future Directions

This small survey (n=50) allowed students in rehabilitation medicine to express their views surrounding the negative aspects of interprofessional collaboration. For many, as students, during education programs is when strong opinions about work and working relationships begin to form. More students from the Faculty of Rehabilitation Medicine should

be surveyed in the future, as roles and responsibilities across Health Sciences professions can differ greatly. Administering a similar survey for healthcare professionals currently working in the field would also prove beneficial because many are working in settings where they are experiencing both the negative and positive consequences of interprofessional collaboration. This data holds the potential benefit of providing insight regarding interprofessional collaboration and positively influencing future policy that facilitates the working relationships between professionals.

A significant finding relating to interprofessional collaboration is that participants were able to identify reasons why problems arise with interprofessional collaboration. This supports the belief that problems persist with interprofessional collaboration and negative attitudes towards interprofessional collaboration are active in individuals even before they enter their designated professions. Further, identifying these potential problems and addressing them before they arise may facilitate more effective interprofessional collaboration. Students, including those surveyed, are the future of the Health Sciences professions and as such will be expected to participate in interprofessional collaboration. Interprofessional education as well as strategies for potential problems could potentially increase the benefits to patient care and professional relationships. Further research on the barriers to interprofessional collaboration within the student and working population will further define the barriers allowing interprofessional education to be developed to overcome them.

Acknowledgement

This research was made possible by the contributions of The Department of Speech Pathology and Audiology at the University of Alberta, Dr. Teresa Paslawski, Dr. Sharla King and the students in the Faculty of Rehabilitation Medicine at the University of Alberta.

Figure 1
Logistics of Interprofessional Collaboration

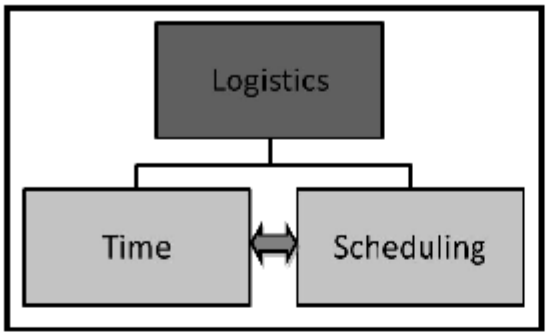


Figure 2
Team Function in Interprofessional Collaboration

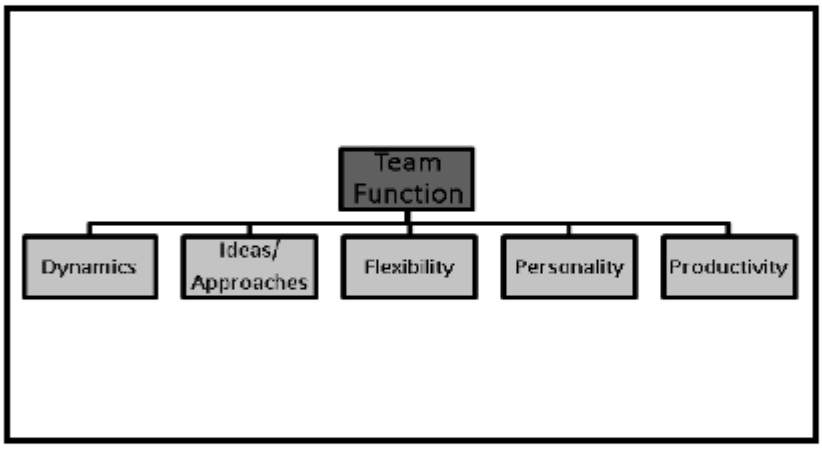
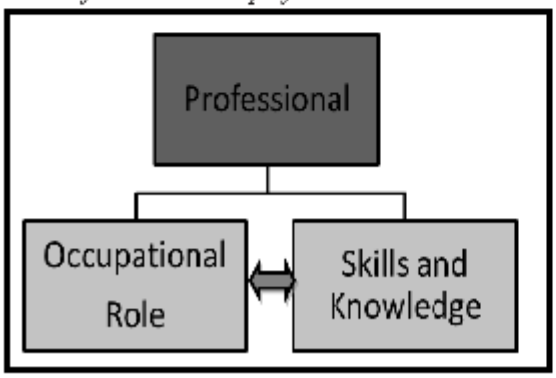


Figure 3
The Professional in Interprofessional Collaboration



Appendix A

Dark Side of Collaboration Survey

Age: O< 29 O30-39 O40-49 O50-59 O60+
O Male O Female
O OT O PT O SLP O Other

Have you had training in interprofessional collaboration? O Yes O No
Explain briefly.

Have you had experience in interprofessional collaboration? O Yes O No
Explain briefly.

What do you dislike about interprofessional collaboration?

If different from above, what do you see as problems with interprofessional collaboration?

What would discourage you from becoming involved in interprofessional collaboration?

Is there anything else you'd like to share with us about interprofessional collaboration?

References

Atkinson, M., Doherty, P., & Kender, K. (2005). Multi-agency working: Models, challenges and key factors for success. Journal of Early Childhood Research. 3, 7-17.

Atwal, A., & Caldwell, K. (2005). Do all health and social care professionals interact equally: A study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences, 19*(3), 268-273.

Conn, L. G., Lingard, L., Reeves, S., Miller, K. L., Russell, A., & Zwarenstein, M. (2009). Communication channels in general internal medicine: A description of baseline patterns for improved interprofessional collaboration. *Qualitative Health Research, 19*(7), 943-953.

Cook, D. (2005). Models of interprofessional learning in Canada. *Journal of Interprofessional Care, 19*, 107-115.

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care, 19*(Suppl 1), 8-20.

Dawson, S. (2007). Interprofessional working: Communication, collaboration... perspiration!. *International Journal of Palliative Nursing, 13*(10), 502-505.

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education, 35*(9), 867-875.

Head, B. (2002). The blessings and burdens of interdisciplinary teamwork. *Home Health care Nurse, 20*(5), 337-338.

Health Cananda. (2001). *Collaborative patient-centred practice*. Retrieved January 1, 2010 from http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index-eng.php

Herbert, C. (2005). *Changing the culture: Interprofessional education for collaborative patient-centred practice in Canada.* Taylor & Francis Ltd.

Ho, K. (2008). The synergy of interprofessional collaboration and social accountability: Their multiplying effects. *Journal of Interprofessional Care, 22*, 1-3.

Horder, J. (2004). Interprofessional collaboration and interprofessional education. *British Journal of General Practice, 54*(501), 243-245.

Jones, A. (2006). Multidisciplinary team working: Collaboration and conflict. *International Journal of Mental Health Nursing, 15*(1), 19-28.

Kilgore, R. V. & Langford, R. W. (2009). Reducing the failure risk of interdisciplinary healthcare teams. *Critical Care Nursing Quarterly. Realities and Myths in Critical Care Practice, 32*(2), 81-88.

Kvarnstrom, S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care,* 22(2), 191-203.

Massey, C. M. (2001). A transdisciplinary model for curricular revision. *Nursing and Health Care Perspectives, 22*(2), 85-88.

Øvretveit, J.(Ed.). (1997).How patient power and client participation affects relations between professions. In J. Øvretveit, P. Mathias, & T. Thompson (Eds.), *Interprofessional working for health and social care* (pp.53-102). MacMillan Press Ltd.

Parker Oliver, D., & Peck, M. (2006). Inside the interdisciplinary team experiences of hospice social workers. *Journal of Social Work in End-of-Life & Palliative Care, 2*(3), 7-21.