Articulating the collaborative ideal
A 50-year exploration in Medical Education

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The ability to collaborate is increasingly seen as a fundamental competency for 21\textsuperscript{st} century clinicians and has been concretized in recent health professions education frameworks.
Collaboration hasn’t always been a legitimate component of health professions education. Five decades ago, doctor-nurse working relationships were constrained by unspoken hierarchical rules that divided expertise along professional lines.
Research Questions

How have notions of collaboration changed over the past fifty years in *Medical Education*? Have the collaborative actors changed over time? Has collaboration itself been transformed by fifty years of scholarship and massive change in healthcare delivery?
Methodology

Scientific knowledge production reflects, reifies and produces broader social and historical trends. These trends partly determine which objects, concepts, people and groups of people researchers see as legitimate, and therefore worthy objects of study. They help materialize the downstream reality of the phenomena they describe.
Methodology

Critically important to understand these dynamics if we want to improve collaboration. With this project our team is aiming to define and shape the collaborative ideal we are striving for.
Sampling

• Built upon an archive of 1,221 articles developed for the larger project;
• Initial coding focused on “interprofessional interactions,” “communication,” “collaboration,” and “coordination;”
• Then narrowed the analysis to those articles which approached collaboration among healthcare professionals (not with patients).
Coding and analysis

The 79 articles selected in this manner were coded using directed content analysis—a method in which researchers use a predetermined framework that they apply systematically to each document, and refine as the analysis progresses.
Initial coding scheme

[who][collaborates][with whom]

Specific attention was paid to the evolution of these linguistic aspects over time.
FINDINGS: Part 1

Who?
Doctors

Unsurprisingly, given that *Medical Education* is a journal about *medical* education, all articles in our sample include doctors—either students, practicing doctors, or medical educators—as part of the collaborative team.

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Over the full time period, doctors are positioned as the main agents of collaboration and the language around doctors’ collaboration is remarkably uniform:

Doctors [collaborate] with others.
“Doctors will have to work much more closely with...other health professions”\(^9(1986)\), and fifteen years later, “...the repertoire of the doctor widens in collaborative team settings to include peer and patient input”\(^{10(2011)}\).
Doctors vs. ... 

“a team approach that includes non-doctor clinicians has received greater attention in recent years”\textsuperscript{16}(2011); and “...when residents do work interactively with interprofessional teams, they...also learn how to work with non-doctor staff”\textsuperscript{11}(2011).
Nurses

Nurses are frequently discussed. They are, however, rarely positioned as full actors in collaborative care delivery. They tend to “help” doctors, enter into conflict with surgeons, but they are rarely instigators of collaboration.

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Students

Often passive: “expos[ed] to students in other disciplines [which] might enhance understanding of the complex processes involved in patient care”\textsuperscript{24}(2001); or “[observe] the professional behaviours of the surgical team and other OR team members”\textsuperscript{25}(2011).
FINDINGS: Part 2

What?
Three main conceptualizations

- As a psychometric property;
- As a task or activity; and
- As “togetherness.”
Psychometric Property

A common conceptualization is collaboration as a psychometric property: knowledge, attitudes, skills, or competencies that are teachable and testable at the individual level.
e.g. Knowledge

… of other professions’ roles and responsibilities: clinicians should “understand each other’s activities”\textsuperscript{32}(2006), know “team structure, leadership and role assignment,”\textsuperscript{33}(2011) etc.

Meanwhile, lack of knowledge is described as detrimental to collaboration.
e.g. Competencies

Sample reflects the turn to competencies in health professions education. A recent model elaborates on Rosen et al.’s Knowledge, Skills and Attitudes framework in which competence is constituted of KSAs\textsuperscript{42(2012)}.

Other authors however conflate competencies, knowledge, skills rather than seeing them as nested or hierarchically related.
Tasks or Activities

Another common conceptualization is collaboration as activities or tasks: particularly structured meetings and the distribution of work.
e.g. Meetings

As early as 1967, social case conferences and group discussions are articulated as “a weapon for the proper education of tomorrow’s doctors”\textsuperscript{43}(1967). Later authors talk about “structured debriefing”\textsuperscript{34}(2012), “debriefing procedure”\textsuperscript{36}(2012) and “protocols such as briefing”\textsuperscript{10}(2011) as key moments of interprofessional collaboration and collaborative decision making.
e.g. Task distribution

“After medical students participated in elective courses with nursing students and social workers, they became more aware of how to use these professionals more fully.” 44(1981).
e.g. Task distribution cont’d

Elsewhere, team members are articulated as genuinely working together: collaboration is “work as part of a professional team”\textsuperscript{40}(1969), doctors and nurses “working together”\textsuperscript{41}(2011).
e.g. Task distribution cont’d

Later, leadership itself becomes “collaborative”\(^{46(2012)}\), yet faced with challenges:

“Members of all four teams, including doctors, questioned the appropriateness of doctor leadership on interprofessional teams […] Despite this recognition, the [paediatric] teams, in particular, felt that doctor leadership was required because of accountability”\(^{35(2014)}\).
“Togetherness”

A subset of authors depict collaboration as professionals coming together around the patient and one another, and articulate it as relationships, conflict management, or shared identities.

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e.g. Relationships... and collaboration

In some texts, collaboration *leads to* better relationships\(^{43}(1967)\) while in others, the development and maintenance of relationships *results in* collaboration.\(^{28}(2012)\)
e.g. Relationships... and conflict

Several recent articles mention conflict and other forms of relationship malfunctions, which include “yelling, insulting and blaming” which “impair[s] working relationships between nurses and surgeons”\textsuperscript{19}(2011).
e.g. Relationships... and conflict

The complicating effects of power, hierarchies and status asymmetries are sometimes discussed. For example, Janss et al. note how “power distribution within the team is complex, may give rise to conflict over status and may also influence how effectively conflicts are managed or resolved.”\(^{36(2012)}\)
The notion that collaboration implies a shared responsibility is both rare and recent. The importance of “fostering a joint professional responsibility” or developing “a sense of collective responsibility”, “mutual aims” or “common goals” is emphasized in some recent articles as a critical aspect of optimal teamwork.
e.g. Shared responsibilities or identities

Others remain critical:

“The oft-cited call for collaborative solidarity … may be widely embraced and irrefutable as a value, but as a motivation for collaborative action it is in constant tension with other relevant motives, such as appropriate resource allocation and trainee education. Multiple equally valuable and competing objectives are part of the complexity of health care teamwork; currently, IPC and IPE models do not sufficiently reflect this complexity.”51(2012)
Conclusion

The culture of healthcare has changed significantly over the past fifty years. Yet our analysis shows that articulations of collaboration can, and continue to, side-line or marginalize “non-doctors.” In many of the articles in our sample, doctors are implicitly or explicitly positioned as the leaders of teams and in ultimate control of patient care.

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The different articulations of collaboration which we found and clustered into three categories are each associated with their own educational interventions and limitations. They are more or less individualistic, never systemic.
We can likely optimize education for collaboration by combining elements from each conceptualization; if each offers a limited window onto collaboration, together they may provide a clearer view of this multi-faceted phenomenon.
But before we enter this educational journey, we will have to ask critical questions:

What is this ideal we strive for? What needs to be done to realize it? How compatible is it with the realities of our healthcare system?
But before we enter this educational journey, we will have to ask critical questions: Is this ideal realistic and actionable, or merely idealistic and toothless?
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