

Toward a Spirit of Interprofessional Practice:

A Hermeneutic Phenomenological Study

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ABSTRACT

Interprofessional practice is recognised as essential in the provision of patient centred, collaborative and high quality care, contributing to improvements in the patient experience and health outcomes. This way of working is expected within healthcare; however, understandings of how best to cultivate practitioners able to ‘be’ and ‘become’ interprofessional remain problematic. To advance that understanding, this study addressed the question: ‘What are health professionals’ experiences of working with people from other disciplines?’

The multifaceted and dialectical nature of interprofessional practice, and the multiple levels of meaning inherent within it, drew me to the hermeneutic phenomenological approach informed by Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002], which underpins this study. This interpretive study seeks to uncover and reveal those aspects of health professionals’ everyday experience with others that point toward what it means to ‘be’ and ‘become’ an interprofessional practitioner. In dwelling with, and gaining a deeper understanding of, the nature of events as experienced in everyday life, a more thoughtful approach to the development of interprofessional learning is opened up, where the ‘being’ and ‘becoming’ can be foregrounded.

In-depth, semi structured interviews with 12 health professionals from nursing, occupational therapy, physiotherapy, speech and language therapy, medicine, social work, and midwifery were undertaken, and their understandings and perspectives of interprofessional practice gathered. The interviews used a conversation style approach, and were recorded and transcribed.

Immersion in the transcripts allowed stories and unifying themes of experience and meaning to emerge, many announcing themselves as important. Interpretation focused on accounts strongly linked to ways of ‘being’ interprofessional and the ways in which these were safeguarded and preserved. Writing and rewriting helped in staying connected to the meanings that emerged from the text, bringing more depth and clarity to the interpretation process.

The experience of health professionals revealed things which appear to be at the ‘heart’ of interprofessional practice, illuminating ways of ‘being’ and ‘doing’ necessary in the turning toward, working in a spirit, and in the safeguarding and preserving of interprofessional practice.

The findings of this research contribute to a deeper understanding of interprofessional practice as a way of being that extends beyond known and measureable skills and knowledge, to dispositions and qualities. Dispositional qualities that come from within a person and what they care about, and from experiences that shape their understandings. This study points toward interprofessional practice as being about a spirit, not a set of competencies. Who people are, what they bring and how they act is what matters.

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ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed:

A handwritten signature in black ink, appearing to be 'BAS'.

Date:

23rd August 2017

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CHAPTER ONE

INTRODUCTION

Practice is so embodied, so tied to the experience (phenomenology) of ones world/life, it is no surprise that the experience of practice is so important in the preparation of healthcare workers.
(van Manen, 1995, p. 47)

‘Olive’ needs health care. The doctor admits her to hospital. The nurse takes care of her. The physio comes to assess her mobility. Later that day the occupational therapist comes and does much the same thing, asking the same questions. On it goes; a stream of health professionals who somehow seem disconnected from each other.

Some years later ‘Olive’ has another health encounter. This time it is quite different. She comes to see that she is the focus of a team of health professionals. They all want what is best for her and listen to her problems and goals. It seems they know each other, respect the skills their colleagues offer, and find ways of working together which leave ‘Olive’ feeling ‘whole’ and cared about.

The question of this hermeneutic phenomenological thesis asks ‘What are health professionals’ experiences of working with people from other disciplines?’

Exploring health professionals’ experience of the ‘being’ and ‘doing’ of interprofessional practice provides a way of seeing what things matter, what things lie at the heart of interprofessional practice and how these things might be preserved and safeguarded. What lies behind ‘being’ and the transition to ‘becoming’ interprofessional is an important topic; not least because those receiving healthcare expect a level of care that moves beyond the knowledge and skills of a single healthcare provider, since there is often more than one individual involved in providing care. It is a level of care that brings with it expectations that those providing it talk to one another, understand the roles of others, respect others’ contributions, and work collaboratively to ensure the best possible outcomes for the person. Regrettably, such a level of care does not always come to pass – as is evident from anecdotes of patient experience and more formal reporting of complaints and adverse events. Forty five percent of patient complaints to the New Zealand Health and Disability Commissioner in 2016 were made because of recurring failures in the integration of care and communication, which resulted in an overall poor standard of care (Health and Disability Commissioner, 2016).

Some of the responsibility for ensuring the transition to ‘becoming’ interprofessional, able to provide person centred, collaborative, holistic and joined up care for people like ‘Olive’, lies with health professional education providers. In my role within the Faculty of Health and Environmental Sciences at the Auckland University of Technology, my remit is to develop and deliver interprofessional education for undergraduate students across 13 clinical and non-clinical health programmes. As such, I seek to create enjoyable, rewarding and supportive interprofessional experiences that reveal, inspire, transform and instil a sense of wonder and understanding for students from a range of health disciplines. Further, I have an agenda that those involved not only find positive and productive ways of working together within the learning environment, but that this way of learning and working will continue into their practice. Being able to provide learning experiences of, and within, practice that enable learners to become interprofessional is the motivation behind this study. Thus, this thesis considers how practitioners from a wide variety of disciplines experience working together in their practice context, which will allow a greater understanding of what it means to ‘be’ and ‘become’ interprofessional.

The study draws on the experiences of 12 healthcare practitioners from 7 different professions to gain a sense of what the experience is like and what it means to them. It gathers and brings to the forefront insights from these experiences to identify what is important for those living it, and to enable different understandings of the phenomenon to emerge. It is hoped insights from the study will contribute to current understandings of interprofessional practice and inform how future healthcare workers might learn to ‘become’ interprofessional.

The hermeneutic phenomenological approach that underpins this study is used to guide the research process and analysis of the participants’ stories. This philosophical approach, informed by Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002], has the potential to generate new understandings of complex phenomena. It delves into the meanings of experience itself (van Manen, 2007), the multifaceted and dialectical nature of interprofessional practice, and the various levels of meaning inherent within it. In this study, new understandings of the phenomenon of interprofessional practice will emerge through the process of reflecting on and interpreting experience, and in the uncovering of meaning within the health practitioner stories of practice.

Understanding the Language

Mindful of the danger of pre-formed understandings, I will not be adopting a specific definition of interprofessional practice, education or learning for fear that this may shut down and limit thinking. Rather I will consider the common assumptions that the terms afford, based on current writing and usage, and will use the terms to point toward a way of being when working with those from different disciplines.

There are many terms used in this field to describe interprofessional practice that have varying definitions and understandings across the different professional groups. These differing understandings have directly impacted on the quality of communication, creating significant barriers in the delivery of care and educational change (Gilbert, 2005; Leathard, 1994; Paradis & Reeves, 2013; Thannhauser, Russell-Mayhew, & Scott, 2010; Thistlethwaite et al., 2014). These differences in understandings, observable in practice and in the literature, may be attributed to a number of factors such as confusion within the field, the background of the authors, and the audience to whom they are speaking (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; Kennedy & Stewart, 2011; Paradis & Reeves, 2013; Thistlethwaite, 2012).

A starting point to discovering the meaning of being interprofessional comes in looking at how it has been defined. The word itself does not exist in the Oxford English Dictionary Online or The Oxford Handy Dictionary, which I had to hand. However, the word 'inter' provides a beginning point for understanding. 'Inter' is defined in The Oxford Handy Dictionary as "between, among, mutually, reciprocally" (Fowler & Fowler, 1978/1989, p. 449). 'Professional' is defined as "belonging to, connected with, a profession" and 'professionalism' as "qualities or typical features of profession(als)" (Fowler & Fowler, 1978/1989, p. 709). In light of this, it could be argued that interprofessionalism entails working with and among others in a mutually reciprocal way, for which certain qualities are necessary.

Despite the fluid and contested nature and meaning of the term interprofessional (Chesters, Thistlethwaite, Reeves, & Kitto, 2011), there has been a trend in the literature since the 1990s toward the use of the term 'interprofessional practice', a term commonly understood as the coming together of multiple disciplines or health workers in the provision of optimal patient care (Centre for the Advancement of Interprofessional Education [CAIPE], 2013b; World Health Organization [WHO], 2010). Those involved in interprofessional practice bring with them their own unique and differing perspectives

and it is this difference which is valued and seen to contribute to successful outcomes (Hammick, Freeth, Copperman, & Goodman, 2009).

Common assumptions related to the all-encompassing term ‘interprofessional education’ include the coming together of learners/practitioners from different disciplines, who interact formally or informally in planned or spontaneous encounters across the education-to-practice continuum, preparing them for interprofessional practice and to work collaboratively in health care teams (CAIPE, 2013a; Institute of Medicine, 2015; WHO, 2010). Learning that comes from these interactions is often referred to as ‘interprofessional learning’. Interprofessional learning has been described as a collective and social process that occurs when learners/professionals learn from, with, and about one another. What sets it apart from other types of learning is its emphasis on learning through the experience of practice (Kemmis & Smith, 2008). It is an active process, requiring interaction and engagement (Freeth, Hammick, Reeves, Koppel, & Barr, 2005). Learning from, with, and about others is an integral part of collaborative practice, making interprofessional learning and practice natural partners in the provision care.

Moving beyond these more formal definitions, Hammick et al. (2009) suggest that ‘being’ interprofessional and being able to work effectively within interprofessional contexts involves knowing the right thing to do, having the skills to do what needs to be done, and having the appropriate values and beliefs to enable practitioners to conduct themselves in the right way. This understanding of being interprofessional points toward certain qualities necessary in the thinking, doing and feeling of interprofessional practice in order to develop reciprocal and mutually respectful relationships between, and among, practitioners from different disciplines. It is said that being interprofessional involves respect, confidence, willingness, a caring disposition and an approachable attitude (Hammick et al., 2009). Is this where the meaning lies? Are these the qualities that enable, sustain, and safeguard effective relationships between and among practitioners, which in turn ensure optimal or high quality care and positive outcomes for patients?

Working interprofessionally implies a certain way of being and “unique ...ways of working” (D'Amour & Oandasan, 2005, p. 9). It is in the everyday experience of working with people from other professions that these ways of ‘being’ and ‘doing’ can be revealed, interpreted and better understood. I seek to find the words that give voice to these experiences, to reflect on and to interpret, in order to come to new insights about the phenomenon of interprofessional practice. Being able to fully capture the meanings of interprofessional practice that allow a common or shared understanding, is recognised

as difficult. This study, through the exploration of participants' stories of interprofessional practice may bring me closer to understanding this term in an ontological manner. While theoretical understandings and theories drawn from more objective positivist science, the ontic, is important to grow a shared understanding of interprofessional practice, so too is the primordial experience of how one understands oneself amidst the dynamic thrownness of being-there (Heidegger, 1927/1962). Understanding is always lived, it is always 'this' understanding from within 'this' situation. As Harman (2007), stated:

Scientific knowledge of any kind... always fails to do justice to the things in the world, which are dark and stormy events locked in a network with other such events, rather than crystal-clear sets of knowledge properties. To some extent, scientific knowledge is always a waltz with illusions, or at least with exaggerations. (pp. 23- 24)

Thus, this thesis takes on the ontological challenge of articulating what it means to be engaged in interprofessional practice.

In this study, a range of terms will be used to describe practices where health practitioners work collaboratively and collegially with people from other disciplines, alongside their patients, in the provision of high quality care. These terms may be interprofessional practice, interprofessional collaboration, collaborative practice or a combination. Interprofessional learning may be used interchangeably with interprofessional education, although the former is more often used to describe the learning that comes from formal or informal interprofessional educational encounters.

For the purposes of this study, I will primarily refer to the recipients of health care as either the 'patient' or the 'person'. However, where participants have used other terms such as 'client', these terms will also be adopted. My decision to adopt the term patient was informed by a study looking at the usage of labels for people receiving healthcare. It was identified that the term 'patient' was considered far less objectionable than alternatives such as 'client', 'customer', 'consumer', 'partner' or 'survivor' (Deber, Kraetschmer, Urowitz, & Sharpe, 2005). I acknowledge that many of the terms used are less than satisfactory, and may work to diminish the person's intrinsic autonomy, and also that variations and preferences exist across the different professions (Shevell, 2009).

Preunderstandings and Impetus for the Study

Gadamer (1975/2013) asserted that all understanding involves prejudice, and if there is acknowledgement of the historicity of understanding then all parties involved in the study can bring their own assumptions and prejudices. My assumptions and pre-understandings

are the starting point of this study and, as the researcher engaged in interpretive hermeneutic phenomenology, the assumptions and understandings of the world I bring to the research will shape the questions asked and the stories shared, as well as my interpretations of how others view the world (Smythe & Spence, 1999; van Manen, 1990). Being aware of these pre-understandings, and recognising that others come from very different vantage points, will contribute to my being able to engage in an open and honest dialogue with participants, allowing movement toward the creation of a shared horizon of meaning (Holroyd, 2008). In uncovering meaning in relation to the interprofessional stories and perspectives, I have opened myself up to new possibilities of understanding but recognise that I will never be able to understand all there is to understand as time, people and experiences are constantly moving and changing (Smythe, 2002).

My experiences have shaped my beliefs and values, and how I interpret and understand interprofessional practice are unique to me. Mindful of where my understandings come from and how this may affect my interpretations or understandings of the participants' experiences, I reflected back on my clinical practice and kept a journal throughout the research journey. I also participated in an interview with one of my supervisors to draw out some of my pre-understandings in relation to interprofessional learning and practice prior to commencing the study. Some of the stories and insights that arose are discussed below.

As a brand new occupational therapy graduate from New Zealand, I found myself working in a large hospital in the east end of London. I was in a country I was unfamiliar with, and in my first job as a registered occupational therapist. I was responsible for the provision of occupational therapy services across four large acute medical wards, an environment I had not encountered as a student. Within a few days of orienting myself to the job, culture, expectations and patient/client group, I met a young new graduate physiotherapist. We would often cross paths when working with the same patient. We soon appreciated that our work had parallels and that ultimately we were working towards the same goals with the patient. I discovered that when we worked together I enjoyed it more than working on my own and we were able to achieve more for the patient in a coordinated and collaborative way. When working together I felt safe and confident and, in drawing on our combined ideas and perspectives, we were able to provide responsive, efficient, creative and more holistic care. It did not matter that our

roles overlapped or blurred; our focus was on the person and what followed became a natural approach to care.

These early experiences instilled in me a strong sense of the value and importance of interprofessionalism for all healthcare workers. As a result, I actively sought to work in this way, which set the tone for how I would continue in my future practice.

I have also been influenced by experiences that have not been as positive. These experiences have only reinforced for me the importance of open and collaborative ways of interprofessional working. One recent experience, which highlighted the importance of ensuring future health professionals move into practice with the necessary qualities to be interprofessional, was relayed to me by close friends who were on the receiving end of healthcare. Their experience was of particular interest to me as it involved a graduate of the programme in which I worked. My friends' son was seriously unwell and had been in a hospital located a significant distance from their home and social networks for about two months at this time. Within the space of a day, he had gone from a happy-go-lucky 8 year old, to being unable to talk, move any part of his body, or make any significant eye contact due to a rare autoimmune response. One sunny and warm Sunday afternoon they enquired as to whether the family could take him for a short walk in the park located next to the hospital. This was greeted with enthusiasm by the nursing staff, who worked with the family to secure the child into a wheelchair and ensure he was warm and comfortable. The walk proved to be the tonic the family needed in a time of great emotional stress, and went without incident. The following day when the family were recounting their experience to the occupational therapist assigned to the child, she was immediately affronted, responding to the family in an accusatory manner. They should not have been allowed to take the child out, it was not safe, the wheelchair had not been set up properly, the child could have been injured, the child would be overstimulated.... They felt scolded and belittled.

Upon hearing this, I tried to make sense of what was going on for the occupational therapist at the time. It appeared that her response exposed a lack of trust in the nurses who had supported the family in this activity. A lack of understanding of the role and contribution of the nursing staff may have led her to believe they did not have the necessary skills to provide an appropriate wheelchair, position the child correctly, or judge the child's status. Was she concerned that the nurses were taking on what should have been her role? Why did she not go and discuss her concerns with the nurses and team instead of directing her anger at this family? Had she had a bad day? Did she think

that her feelings or contribution were more important than the other professionals involved in the child's, and indeed this family's, care? Could she not see the stress and pressure the family were under and that the benefits might outweigh any possible negative effects? I was at the time incensed by her actions from both a personal and a professional perspective. In addition to the questions it raised for me, I reflected on her educational experiences, what may have been missing and what could have been done differently that would have better prepared her for this scenario?

The experience described by my close friends, led me to wonder what it was about people and these healthcare encounters, that enabled some health professionals to work effectively together and others not, and what were the things that enabled and sustained an interprofessional way of 'being' and 'doing'? I began to consider the qualities necessary for effective interprofessional collaboration.

Later on, in my role of developing interprofessional learning activities for undergraduate health students, I came to understand interprofessional practice through the lens of 'interprofessional competencies', or the knowledge, skills, attitudes and values that have been identified as necessary for this way of working. I recognised and could relate to these 'competencies' from my own practice, but I was also conscious of other factors that come into play in the ordinary everydayness of practising with others that could not easily be explained or pinned down via an interprofessional competency framework. Factors like kindness, respect and feeling valued.

That interprofessional practice is complex and multifaceted was not the thing that concerned me most. What troubled me more was the fact that much of what I considered important for working interprofessionally and in managing this complexity was not easy to identify, pin down, understand or teach. There did not seem to be anything that fully captured the interprofessional practice I had experienced, the qualities I sensed were important in becoming an effective interprofessional practitioner, or indeed the best ways to learn them.

How can educators adequately prepare health graduates for interprofessional practice? Gaining more of an understanding of how interprofessional practice is actually experienced and the "relationality of participatory workplace practices" (Radomski & Beckett, 2011, p. 100), I felt would assist in identifying the things that support interprofessional practice. I was not alone in thinking this way. Radomski and Beckett (2011) proposed that

more context sensitive accounts of practice based interprofessionality.... are urgently needed to push current conceptions of interprofessional education [IPE] into new territory....we must turn to the real world to learn from the contingencies, sociality and diversity of everyday clinical practices. (p. 100)

What is known about the experience of interprofessional practice by those doing it and the meanings they attach to it that could help inform and shape the way we support and teach health graduates to become collaborative and practice ready? As I set out on this study, my own belief was that the qualities they know from practice should be at the forefront and embedded within the student experience.

Placing the Study into Context

This study took place in New Zealand and drew on health practitioners who all had experience of working within its healthcare system, with over half also having completed undergraduate degrees within the New Zealand tertiary education system. All of the 12 participants had worked in Auckland, with many drawing on their experiences here and other parts of the country, as well as other parts of the world. To contextualise the real world relational and participatory experiences of healthcare workers and the influences on interprofessional practice, an understanding of some of the practice and learning contexts and the diversity and influences on everyday clinical practices is necessary and outlined below.

The New Zealand healthcare context: Health strategy and reform

New Zealand has undergone significant reforms to its publically funded health sector over the last few decades. Although each has varied in emphasis, some of the enduring and consistent themes to come from the proliferation of government policy and strategies are the need for patient involvement and focus, effective communication and interprofessional, as well as interagency, collaboration.

The reforms involved changes to the way the health system is structured, which has in turn driven changes in how health services are delivered. With the neoliberal government in the 1990s came the introduction of a market oriented health service characterised by competition, contracting and a purchaser provider split (Gauld, 2009). The subsequent reorganisation of the health system called for significant structural changes which aimed to encourage efficiency and flexibility, reduce health spending and ensure fiscal transparency, improve consumer access to and choice of health services, enhance the working environment for health professionals and ensure the health system was responsive to the needs of communities (Gauld, 2009). Cumming (2011) suggested that

there were positive as well as negative consequences of these reforms and, although there may have been a greater choice of providers and improved services for consumers, along with this came greater fragmentation and reduced incentives for collaborative practice. Attempts were made to promote service integration, with some funding provided to a number of integrated care projects but they were something of a passing fad, remaining deeply unpopular and leading to an overall reduction in staff morale and increased administrative confusion (Gauld, 2009). In 1999, the new centre left government began once again to redesign the health and disability sector. It aimed to improve the overall health status of New Zealanders through increased community involvement, local decision making and public health initiatives, reduced inequalities, and the integration of services, particularly primary and hospital based services (Gauld, 2012). A significant area of reform was in the primary health care sector, where discussions had begun under the previous National (centre right) government to move toward multidisciplinary teams of health practitioners providing the first point of contact for patients (Gauld, 2009). The emphasis was on multiprofessional care, health promotion, addressing the needs of people with complex and chronic conditions, and improving access to primary health services via primary health organisations (A. King, 2001).

At the same time as changes were being made to the structure of the health sector, The New Zealand Health Strategy 2000 was developed which emphasised an accessible, equitable and improved health care system for all New Zealanders. It articulated key health priorities as well as the operational framework within which newly formed District Health Boards (DHBs) and other health organisations would operate (King, 2000). The changes were aimed at ensuring a focus on the needs of the population, a reduction in disparities, an emphasis on person centred and community involvement, a collaborative environment which encourages cooperation, and the coordination and involvement of a range of disciplines in the delivery of services (King, 2000). The strategy referred to a number of priorities that align with some of the characteristics identified as central for effective interprofessional practice, including patient centred care, interprofessional communication and teamwork. The strategy did not, however, provide information on how its identified priorities would be met, instead relying on existing and planned strategies to act as toolkits for the implementation of each of these priorities (King, 2000). The New Zealand Disability Strategy (2001), which was developed alongside The New Zealand Health Strategy (2000), aimed to guide the development of health and disability services in New Zealand (King, 2000; Ministry of Health, 2001). A key principle was patient involvement and choice in relation to its aim of creating a more inclusive society

(Ministry of Health, 2001). However, it also lacked specific guidance for how to implement its key objectives.

In 2001 the Primary Health Care Strategy was published with a specific focus on improving population health, the coordination of care and reducing inequalities (A. King, 2001). The strategy was to act as a guide for DHBs, which are responsible for planning and allocating resources for primary health care services (A. King, 2001). A key feature of this strategy, in terms of how services were to be delivered to best meet the needs of populations, related to the collaborative or interprofessional nature of service delivery. “Improved co-ordination of services was to include collaborative... as well as inter-sectoral work (within a range of social welfare agencies) to address health issues” (Cumming, 2011, p. 4). However a study by Pullon, McKinlay, and Dew (2009) suggested that despite a strengthening of health policy to support primary health care, there has been a lag in aligning training and educational policies to support the workforce in this environment. They identified that a number of external factors that have constrained the ability of primary health care practitioners to work in interprofessional teams, remain. One of those was that health policy and the associated primary health funding models only partially supported interprofessional collaborative practice. Another external factor indicated that effective teamwork was reliant on individual Primary Health Organisations instituting good business practices. A lack of opportunities available for interprofessional learning for primary health practitioners was also evident, despite practitioners’ acknowledgement of the value of interprofessional learning in engendering collaborative practice. That situation existed despite some commentators’ belief that training in how to work effectively in teams is required for all primary care practitioners in order to deliver optimal care to individuals and communities (Pullon et al., 2009). Thus, despite calls for greater teamwork and collaboration, barriers to its effective implementation within the New Zealand primary health sector remained.

Closely following the 2001 Primary Health Strategy came He Korowai Oranga: Māori Health Strategy (2002), which built on the principles of the New Zealand Health Strategy and the New Zealand Disability Strategy in supporting Māori families to realise maximum health and wellbeing. It emphasised inter-agency collaboration and whānau¹ centred approaches in achieving these ends (King & Turia, 2002). More recently an inter-agency strategy, Whānau Ora, was developed to assist in the achievement of maximum

¹ Whanau - Māori term understood as extended family, family group; a familiar term of address to a number of people.

health and wellbeing for Māori families (Durie, Cooper, Greenell, Snively, & Tuaine, 2010). Whānau Ora puts whānau at the centre of care and is based on the understanding that the best people to make decisions in relation to their health and wellbeing are families (Matheson & Neuwelt, 2012). This clearly aligns with interprofessional discourse in relation to the patient/family/community being positioned at the centre of care.

In 2008, leadership changed back to the National Party who had, a year earlier, released the 'Sooner, Better, More Convenient Health' discussion paper. Some of the key principles included putting patients at the centre of their care, engaging in shared decision making, and providing seamless care where health professionals and health organisations work together in partnership (Ryall, 2007). How health professionals and organisations work together to provide care, and recruiting and retaining a responsive and capable workforce, were all identified as key success criteria (Ryall, 2007).

More recently, in the New Zealand Health Strategy Future Directions (2016) document, the National government emphasised the need for a health system focussed on people, one that involves the public in designing health services and one that better understands people's needs (MoH, 2016). A key feature of the strategy is the notion of 'one team' where collaborative and high trust teams work to provide optimal healthcare, which aims to reduce fragmentation and barriers.

The increasingly explicit association of collaboration amongst health professionals and optimal healthcare outcomes evident in New Zealand policy, aligns with international developments. Interprofessional practice is recognised globally as a central element in developing effective and sustainable health systems and creating health services and health professionals that support and complement individual discipline capabilities by reducing duplication, improving job satisfaction, overcoming fragmentation in service delivery and improving patient satisfaction, safety and quality (Reeves, van Soeren, MacMillan, & Zwarenstein, 2013; World Health Organization, 2010). However, while the hallmarks of interprofessional collaborative practice have been consistently signalled in New Zealand health policy, having an understanding of the things that matter, the things that contribute to its effectiveness and sustainability, as well as specific guidance for its implementation, remains largely lacking and a challenge for health practitioners, health educators and health planners.

The New Zealand healthcare context: Professional legislation

Health regulatory authorities for individual health professions have a responsibility to ensure the safety of consumers using those professions' services, and are required to meet the specifications of the Health Practitioners Competence Assurance Act (2003) [HPCAA]. The HPCAA (2003) is the legislative framework which ensures the ongoing competence of health practitioners, thereby protecting the health and safety of members of the public (Ministry of Health, 2012). How each of the health regulatory authorities established under the Act chooses to ensure that health practitioners within their profession meet the specifications of the HPCAA, impacts on both interprofessional practice and learning. The Act mandates that the regulatory body for each health profession is responsible for setting and monitoring standards of clinical and cultural competence as well as ethical conduct (Ministry of Health, 2017). The HPCAA demands that each profession covered by the Act make its own statement about how that group will practice. Each regulatory body sets its own list of competencies that practitioners are required to meet, as well as determining its own monitoring arrangements to ensure competence is reached and maintained. Each profession has independently identified its competencies for practice (Ministry of Health, 2017); however, upon examination significant commonalities exist (albeit implicit or described using different language), most of which directly or indirectly identify effective communication, the central role of the patient, collaboration and teamwork as core professional competencies (Nursing Council of New Zealand, 2012; Occupational Therapy Board of New Zealand, 2010; Owen, 2009; Physiotherapy Board of New Zealand, 2009).

A Ministry of Health document entitled '2012 Review of the Health Practitioners Competence Assurance Act 2003', identified a need for the HPCAA to balance issues of public safety with the integration of care and development of new models of service delivery (Ministry of Health, 2013). It highlighted a number of issues with the potential to impact on the provision of integrated care. These included developing communication and teamwork capabilities, standardising codes of ethics and conduct for the health professions, and promoting broader and common education and training for all of the professions represented under the HPCAA (Ministry of Health, 2013). The idea of standardising health professional codes was put forward for discussion within the HPCAA review document, and the majority of submitters thought this made some sense given the degree of similarity that already exists (Ministry of Health, 2012).

Professional associations and regulatory bodies have a pivotal role as they “are the arbiter of whether interprofessional education and patient-centred collaborative care may move forward” (Gilbert, 2005, p. 93). A Health Workforce Australia national audit of interprofessional education in that country also recognised this. It highlighted the need for a common interprofessional language for interprofessional practice and education to be embedded into accreditation standards for all registered health professions, for a national agreement on what core competencies should look like, as well as a requirement for interprofessional practice and education to be embedded into continuing professional development frameworks for ongoing registration (The Interprofessional Curriculum Renewal Consortium, 2013).

The HPCAA has to find a balance to ensure it protects the public and enables health practitioners to work in ways that enhance care quality and safety. The fact that there are already a number of existing clear interprofessional competencies embedded into the regulatory authorities’ competency documents for the health professions, suggests that these things are considered important and contribute to the provision of safe and high quality care.

Although the door is open for interprofessional practice and education in New Zealand, a number of factors come into play to close it again. The HPCAA calls for collaboration, but sets up regulatory bodies separately, creating a competitive environment rather than a collaborative one. Arguably, if the HPCAA demanded, and incorporated into the Act, more explicit recognition, standardisation and alignment of the core or common competencies and codes of ethics and conduct across the health professions, a platform for future interprofessional collaboration and education would be provided. This may provide the catalyst that health planners and educators need to pursue and grow interprofessional opportunities to develop the necessary interprofessional qualities/competencies in the most effective way.

Despite recognition of the critical role interprofessional education plays in supporting and underpinning interprofessional collaborative practice (WHO, 2010), there remain only glimpses of this within health policy and health professional legislation in New Zealand. There continues to be a disconnect between the interprofessional education and collaborative practice rhetoric, and the actual practices necessary to ensure it happens.

The New Zealand health education context

Although interprofessional education has been identified as an effective vehicle in the development of interprofessional teamwork, communication and patient centred care (WHO, 2010), its implementation remains challenging. The task of developing interprofessional education across multiple health education programmes has been described as challenging and fraught with obstacles (Cook, 2005; Deutschlander, Suter, & Lait, 2012; Gilbert, 2005; Ginsburg & Tregunno, 2005; Pickering & Embry, 2013) and this has been my experience of interprofessional education development within tertiary education.

My experience of interprofessional education development in New Zealand aligns with some of the reported challenges internationally. Challenges such as traditional siloed approaches to the education of health professions perpetuating stereotypes, professional rivalry, and power imbalances between disciplines, all hindering health practitioners' ability to work as part of a team (Chung et al., 2012; Hall, 2005; Mandy, Milton, & Mandy, 2004; Swisher, 2009). The lack of a common language across the health professions, and differences in terminology used and understandings between disciplines have impacted on the quality of communication and health practitioners' ability to work interprofessionally (Gilbert, 2005). Other barriers to the development and implementation of interprofessional learning within tertiary education organisations have included organisational readiness for change, leadership commitment, professional regulatory body requirements and expectations, and financial and resource availability (Gilbert, 2005; Ginsburg & Tregunno, 2005). Pragmatic issues such as already full curricula, misalignment of clinical placements, a lack of facilities and a limited supply of suitably trained interprofessional facilitators also act as barriers to the effective development and implementation of interprofessional learning (Gilbert, 2005; Ginsburg & Tregunno, 2005).

Within the Faculty of Health and Environmental Sciences at the Auckland University of Technology, where I work, change at an individual, organisational and systems level in relation to the implementation of interprofessional education is underway. In 2009 the university supported the establishment of a National Centre for Interprofessional Education and Collaborative Practice (NCIPECP), opened by the then Minister of Health. This proved to be a turning point for interprofessional education within the Faculty of Health and Environmental Science, with the Centre playing a key role in driving change locally, but has yet to make its presence felt at a national level. This has

been in part due to the differences in organisational readiness for interprofessional education and practice throughout New Zealand.

A significant step toward an interprofessional vision also occurred in the early 2000s as the faculty instituted a common core curriculum in the first semester for all of its programmes (Jones, McCallin, & Shaw, 2014). Currently, up to 1760 students in a single semester, from 17 science and health disciplines including nursing, midwifery, paramedicine and emergency management, occupational therapy, podiatry, physiotherapy, psychology and oral health, all come together in primarily shared learning situations across a number of papers, with increasing opportunities for interprofessional learning. The core curriculum and a number of other shared papers sit within the School of Interprofessional Health Studies, which actively works to support and develop interprofessional learning across the faculty.

Staff with a focus on interprofessional education within the faculty have drawn on various international experiences and literature to inform interprofessional development, including the introduction of a model of interprofessional education developed and adapted from work at the University of British Columbia (Charles, Bainbridge, & Gilbert, 2010). The model was originally developed on the premise that learners are at different stages of readiness for interprofessional education and have specific learning needs at different times in the learning process. This has enabled the faculty to begin to plan what types of learning should be offered, when. The faculty also drew on the interprofessional competency framework developed by the Canadian Interprofessional Health Collaborative (Canadian Interprofessional Health Collaborative, 2010), which specifically describes competencies for effective interprofessional collaboration, which has to date provided a guide for learning material contained within the interprofessional education encounters.

In addition to first year students being exposed to interprofessional practice concepts and interprofessional learning activities within the common core semester, there are additional interprofessional learning opportunities available. Two notable interprofessional programmes based within the university clinic provide students with an opportunity to learn from, with, and about one another in a practice context, while concurrently providing a service to the local community. The first is an interprofessional, student-led programme for people with type 2 diabetes (D. O'Brien, McNaughton, Flood, Morgan, & Bowmar, 2016). It aims to support the person's ability to optimise his/her lifestyle choices for improving health outcomes and involves between 9-14 students from

up to 7 disciplines working collaboratively in the provision of care for up to 14 people. The programme focuses on the person's identified goals where the students work collaboratively in undertaking interprofessional assessments, group education for the patients and a range of interventions. The second programme is called 'Living Well' and is directed at individuals who have experienced a significant health condition or life event that has challenged their ability to adapt to their life circumstances. Students utilise a holistic care approach to individual and group sessions, which allow the person and students to explore approaches to living with life changing conditions as well as providing students with the opportunity to develop qualities for future interprofessional practice.

Other interprofessional activities include an annual health care team challenge event which brings students and new graduate practitioners from across New Zealand together into interprofessional healthcare teams to plan care for a person with complex health and social needs (B. Flood, O'Brien, & Jones, 2016). The New Zealand Interprofessional Health Conference, another event led by the School of Interprofessional Health Studies and supported by the NCIPECP, has begun to establish itself as a key national platform for interprofessional education and practice. Interprofessional research is part of the integrated vision of the interprofessional development team within the faculty, providing evidence for the value of interprofessional learning and practice programmes and raising its profile.

Outside of the shared papers, interprofessional learning opportunities for health students within the faculty have increased overall in recent years but predominantly remain small scale, without formal assessment or academic accreditation, and driven by a few interprofessional champions. Despite what continues to be a limited number of interprofessional opportunities across the faculty, it has begun to gain traction and momentum with the appointment of staff specifically involved in interprofessional practice, education and research.

Mindful of the reported and experienced barriers to its implementation, this study aims to inform future interprofessional education development within the faculty. The findings from this study will find immediate application across the faculty and more specifically within the School of Clinical Sciences. This school has committed to a change in how its 7 health disciplines work toward developing the necessary qualities for collaborative practice, through the development of an interprofessional curriculum.

Overview of Thesis

This study sets out to explore health professionals' experiences and perspectives of working with others to reveal what it might mean in the 'being' and 'doing' of interprofessional practice. The quest is to ask what can be learnt from these experiences that may help to better prepare future healthcare practitioners able to work together in the provision of high quality care within interprofessional contexts. The study is situated within a particular personal and professional horizon, and health and education context. The use of a hermeneutic phenomenological methodology means that new understandings about interprofessional practice can be opened up.

The study is presented in eight chapters, with this chapter setting the scene by introducing its purpose, impetus and the context in which the study is situated. The literature review that follows in chapter two provides further contextualisation by exploring and synthesising the existing relevant literature related to the topic. It shows a link between the literature and the research question, highlighting its complexity and gaps in current understandings.

Chapter three discusses the philosophical approach to the study, and introduces some of the guiding philosophical notions from Heidegger and Gadamer that have underpinned my thinking. The reasons hermeneutic phenomenology was selected as a methodology are also discussed in relation to the research question.

How the research was undertaken is described in chapter four. It outlines the methods used including the ethical approval process, the selection and recruitment of participants, the gathering and analysis of data in the form of participant stories, and the writing up of the study's findings.

Chapters five, six and seven are where the findings from the study are presented. Each chapter includes extracts from participants' stories, as well as interpretations from the researcher to reveal those things considered important. These chapters draw on Heideggarian and Gadamerian notions to elucidate and support the discussion. The first findings chapter, chapter five, discusses things that influence health practitioners in the turning toward or the turning away from calls to collaborate. Chapter six shows the relational nature and complexity of interprofessional practice, and illuminates a number of aspects which, when gathered together, act to enable practitioners to work in a spirit of interprofessional practice. Chapter seven highlights key aspects which appear to be important in safeguarding and preserving this spirit of interprofessional practice.

The concluding chapter considers the original research question in relation to the study's findings. The findings are summarised and discussed in relation to current scholarly thinking and the literature. Implications for practice, education and research are outlined, along with the limitations of the study.

Summary

This study seeks to explore the everyday experience of health professionals engaged in interprofessional practice and uncover, question and gain a sense of understanding of the perspectives and meanings they attach to it; meanings which become covered over in the 'everydayness' of practice. Within the following chapters, I will explore and illuminate those things considered to be at the heart of interprofessional practice, things which call, enable, and safeguard a spirit of interprofessional practice. These insights, post thesis, will go on to inform my role in establishing innovative, relevant educational opportunities for interprofessional learning that will hopefully prepare graduates to work collaboratively with colleagues from a variety of disciplines.

CHAPTER TWO

RE-VIEWING THE INTERPROFESSIONAL LITERATURE

*The 'fore' is always part of understanding. It can be no other way.
The danger is that 'already understanding' can limit, shut down or distort.*
(Smythe, Robinson, & Scrimgeour, 2007, p. 500)

This chapter seeks to bring an understanding of how the experience of 'doing' interprofessional practice and 'being' an interprofessional practitioner has been shaped, and is being shaped, by current understandings of interprofessional practice and education from related literature. It seeks to provoke thinking by encouraging readers to dwell, to ponder and to question (Smythe & Spence, 2012), and aligns with the study's philosophical tradition. "Only in conversation, only in confrontation with another's thought that could also come to dwell within us, can we hope to get beyond the limits of our present horizon" (Grondin, 1994, p. 124). I came to this study with a particular horizon of understanding, an already-there prejudice that provided a lens to make sense and draw meaning from the texts. My horizon is ever-changing in the on-going process of conversing with the literature. Others reading this study will draw their own meanings by engaging in dialogue with the text as ideas relate to their own experience and context.

I have not come into this study thinking that it would enable a complete understanding of what the experience of being an interprofessional practitioner means or the best ways to learn how to become one. Rather I have sought to open a dialogue from which understanding of the things that matter to those engaged in interprofessional practice can be illuminated. Understanding is a negotiation between past and present; texts of the past have much to contribute to the present (Gadamer, 1975/2013), and with this in mind the chapter will consider a spectrum of the interprofessional literature, making visible what it might mean in the 'doing' and 'being' of interprofessional practice, education and research.

In drawing on the literature, and in writing this literature review, I recognised and acknowledged the role my own unique experiences and prejudices have had on the study, in both the selection of texts and in the interpretation of this literature. They cannot just be ignored or put aside, but as noted by Gadamer (1975/2013) "all correct interpretation must be on guard against arbitrary fancies and the limitations imposed by imperceptible habits of thought, and it must direct its gaze 'on the things themselves'" (p. 279). For

Heidegger, everyday understanding comes from something already there, or *fore-meanings* (Heidegger, 1927/1962). The *fore-meanings* which I bring to this study can act to distract me from the ‘things themselves’, which in this case refers to the ‘thingness of the thing’ that is interprofessional practice and the sensibilities that surround it (Heidegger, 1927/1962; van Manen, 2014). These *fore-meanings* include: my already understood, taken for granted, advance understanding or *fore-having* related to the phenomenon of interprofessional education and practice; *fore-sight*, a seeing in advance which brings a sense of where and what to look for in terms of the literature that has guided me in this review process; and *fore-conception*, an already-there sense of what might be encountered and what the research might look like, which has created a new horizon of understanding (Smythe & Spence, 2012). An awareness of the origin and legitimacy of the *fore-meanings* that I have brought to the study prompted me to act with caution. These understandings shaped in advance were examined, questioned and expanded through philosophical and topic specific immersion, as well as actively broadening the literature search base (Gadamer, 1975/2013; Heidegger, 1927/1962; Smythe & Spence, 2012; van Manen, 2014). I have remained prepared and open to the meanings of the other, and texts. “The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s fore-meanings” (Gadamer, 1975/2013, p. 282).

This literature review will present an argument informed by the *fore-meanings* I bring to the study and the meanings I have drawn from the literature, but it must be acknowledged that it will never be complete. There will always be other ways of interpreting the information and other conclusions to be drawn. It aims to reveal taken for granted meanings that have informed the knowing ‘of and about’ interprofessional education and practice (Smythe, 2011).

The chapter will start by presenting a bigger picture, of the wider discourses related to interprofessional education and practice, exploring the explicated meanings, the drivers for its development and continued growth, and the research findings from the scholarly literature. Much of this literature informed my early understandings of interprofessional education and practice and contributed to the shaping of the interprofessional learning activities I was tasked with developing. With so much written about interprofessional practice and education, and the growing emphasis and resources being put toward its incorporation into pre- and post- registration health education, I began to question what was informing its development and to consider afresh the role of those engaged in the

doing and being of interprofessional practice. It was in coming to know the field, the contemporary and historical literature on the topic and my experiences in practice and education that I identified a gap in the literature which contributed to the development of my research question. There was much writing of an ontic nature, defining, describing and theorising the nature of interprofessional practice, but few ontological accounts about the experience of practitioners who worked closely with colleagues from other disciplines. The second part of this review will focus on the literature more closely related to my research question and will consider health practitioners' experiences of the 'being' and 'doing' of interprofessional practice and how/whether their experiences, meanings and insights have informed interprofessional learning.

Searching for Literature

I looked to the literature for perspectives on health practitioner experience and understandings of working with other disciplines, assuming that real world, first-hand accounts would provide insights to inform the development of better working and learning practices. My already-there involvement in the world of interprofessional education and practice, including my interprofessional role, relevant conference attendance, previous study and daily dialogue with others, meant I already had access to a wide pool of literature and resources. In addition, manual searches were undertaken using citations and reference lists and a number of health databases were accessed. A literature search was undertaken specifically to capture those texts related to practitioner experience of collaboration and involved using the following health databases; CINAHL, Medline via EBSCO and Scopus. It started with a more general exploration of the interprofessional literature and was refined to specific search terms in order to capture relevant texts related to the lived experience of collaboration. The limiters included literature written within the last 10 years and in English only. The search terms are detailed in Table 1 (see p. 34).

Background

Despite the relatively recent public emergence of interprofessional education and collaborative practice, health care has always been delivered by teams of health workers of one description or another (Bainbridge & Purkis, 2011). Although not perhaps 'interprofessional' teamwork as understood in today's healthcare context, its opportunities and challenges were recognised in 1968 by Lindenfield:

Some would say that this development [working with other professions] is good because we need many helpers. The fact remains, however, that when so many

actors move on the stage there is a danger of rivalries, jealousies, and a kind of upstaging that does no credit to the actors and more importantly makes the production a sorry spectacle for those who were to benefit. (p. 3)

Table 1: Literature Search Terms

Concept	Proximity terms
Interprofessional	(interprofessional N5 team*) OR (multidisciplinary N5 team*) OR (interdisciplinary N5 team*) OR (interprofessional N5 collaborat*) OR (multidisciplinary N5 collaborat*) OR (interdisciplinary N5 collaborat*)
Experience	"lived experience*" OR (professional* N3 experience*) OR (employee* N3 experience*) OR (experience* N3 collaborat*) OR hermeneutic* OR phenomenologic*

*Denotes truncation

Strong disciplinary boundaries, issues of gender, class, hierarchical power and knowledge, have been and remain as challenges in the development of interprofessional education and collaborative practices in contemporary health and education sectors. More formal recognition of both interprofessional practice and interprofessional learning was determined as important in addressing health needs in 1978, featuring prominently at the World Health Organization [WHO] international conference on primary care and the Declaration of Alma-Ata (WHO, 1978), and later in the WHO (1988) technical report, 'Learning Together to Work Together'. Interprofessional practice and interprofessional learning have emerged over the last 40-50 years in response to increasing recognition that learning and working interprofessionally can address some of the increasing demands and complexities in health care (Frenk et al., 2010; Institute of Medicine, 2013; Reeves, Tassone, Parker, Wagner, & Simmons, 2012; Suter et al., 2012; WHO, 1978, 1988, 2010).

Interprofessional practice and learning is gaining impetus within both health and tertiary education organisations. Health policy makers around the world have identified the need to consider alternative models of care to improve health systems and health outcomes. This shift has been in response to the growth in the aging population, the increase in

people and communities with complex needs, the deepening worldwide shortage of health care workers, recognition of the impact medical errors have on the lives of patients and the associated costs and demands placed upon organisations in a fiscally constrained environment (Reeves et al., 2012; WHO, 2010). Given these challenges, a recent WHO high-level commission on health employment and economic growth recognised the importance of ensuring both the right number of jobs as well as the right skills for health workers in the delivery of care targeted in the right places (WHO, 2016c).

Driver for change: Complexity and health workforce crisis

With the fragmentation of many health services globally, as well as a rise in the complex challenges of a growing aging population, chronic conditions, communicable diseases and mental health issues, calls have been made for a health workforce able to work collaboratively in a people centred way in areas such as health promotion, disease prevention and community-based services, in order to deliver care effectively and efficiently (Hall, 2005; WHO, 2010; 2013, 2016c). No one health practitioner can provide the broad spectrum of knowledge and expertise required in the provision of comprehensive health services, which requires an unprecedented amount of care coordination and teamwork; therefore, it is argued that health professionals need to work together (Fagin, 1992; Frenk et al., 2010; WHO, 2010). The WHO (2010) argued that in order to move health systems from a place of fragmentation to a place of strength, an interprofessional and practice ready health workforce is required; a workforce that understands how to work together to provide effective care to the population it serves.

A responsive, collaborative and integrated health workforce is one challenge, but the WHO (2016a) projected a need for an extra 40 million health workers globally by 2030 to meet the growing demands within the sector. In response to the deepening human resource shortage in health sectors across the world (WHO, 2010, 2013, 2016c), it is recognised that there is a need for timely and significant investment to create new jobs (WHO, 2016b). Urgent attention to transforming and scaling up health professional education in order to ensure health workers are ‘fit for purpose’, able to meet the needs of populations and thus achieve the right mix of skills and competencies, is required, as “simply training and graduating more health professionals is not the answer to this vexing issue” (WHO, 2013, p. 11). Interprofessional education has been identified as a key mechanism in the development of core competencies necessary for ensuring a ‘fit for purpose’ workforce able to collaborate and work effectively in teams. A ‘fit for purpose’ workforce, as described by Pálsdóttir et al. (2016), is one where there is an understanding

of the culture, needs and assets of the local communities in which they serve, which in turn facilitates the development of necessary competencies.

Some of the challenges in addressing workforce issues related to having sufficient numbers of health workers appropriately skilled to deal with complex problems, are due to misconceptions held by “political leaders, policymakers and economists who still view health employment as a burden on the economy” (WHO, 2016c, p. 16). This is contrary to understandings that investment in the health workforce would not only improve overall productivity in the sector but would improve health outcomes, health systems and ultimately build stronger economies as a whole (WHO, 2010, 2016c). A high-level commission on health employment and economic growth tasked with stimulating and creating 40 million new jobs in the sector, and reporting directly to the United Nations, identified the need to address the lack of investment which they believed to be the root cause of insufficient development of health workers with the necessary skills required to meet the needs of the populations they serve (WHO, 2016b). Developing an appropriately skilled health workforce to meet growing health challenges requires a different approach, a different model of care and a workforce with the right competencies to respond to changing health profiles (WHO, 2010, 2013, 2016b, 2016c). This has been challenging to achieve when there has been a disproportionate focus on educational practices that preserve professional silos and achieve the opposite of preparing the workforce to work collaboratively in teams (Frenk et al., 2010; WHO, 2010; 2013, 2016c).

A recent framework on integrated, people-centred health services, produced by the WHO, also recognised the challenges of delivering responsive and high quality care in a global environment where millions worldwide remain without access to healthcare, and where those with access are reliant on fragmented, hospital based, disease focussed and siloed models of care (WHO, 2016a). The framework proposes an approach to care that is responsive to the needs of people and the people who care for them, that is effective, safe, comprehensive and coordinated, and is provided by health workers who have the necessary skills and motivation to work within supportive environments (WHO, 2016a). Providing training and education for health workers to develop skills necessary for such things as working in team based environments is integral to this framework (WHO, 2016a). In addition to developing the necessary knowledge, skills and attitudes of the health and community providers caring for people with chronic and complex conditions, to ensure the ongoing delivery of effective and coordinated care (Bookey-Bassett,

Markle-Reid, Mckey, & Akhtar-Danesh, 2017), the use of collaborative care models such as the Chronic Care Model has been shown to be effective in improving their health outcomes (Southerland, Webster-Cyriaque, Bednarsh, & Mouton, 2016).

Investing in a health workforce with the ability to provide the right services to meet complex individual, community and population needs requires an investment into how they are educated. One of the recommendations to come out of the high-level commissions report, in addition to growing the workforce, was to “scale up transformative, high-quality education and lifelong learning so that all health workers have skills that match the health needs of populations and can work to their full potential” (WHO, 2016c, p. 11). The commission’s vision is for the health workforce to be expanded, transformed, sustained and enabled to improve health outcomes in an equitable, cohesive environment, which will contribute to fostering the economic growth in the countries it serves (WHO, 2016c).

Driver for change: Patient safety

The recognised relationship between interprofessional learning and practice, and quality of care and patient safety, remains at the top of health policy agendas in developed countries, spurred on by various international reports highlighting the significant harm to health care consumers that can occur when things go wrong (Gauld, 2009). This was particularly evident in two high profile international reports, ‘Too Err is Human’ in the USA (Kohn, Corrigan, & Donaldson, 2000), and a UK report, the Mid Staffordshire National Health Service (NHS) Foundation Trust public inquiry into serious healthcare failings between 2005 and 2008 (Francis, 2013). Both reports identified a lack of interprofessional collaboration and, more specifically, a lack of or ineffective interprofessional communication, respect and teamwork. These unfavourable findings also feature prominently in other reports into adverse events in New Zealand and around the world (Brown et al., 2002; Gauld, 2009; Health Quality and Safety Commission, 2012; Maplesden, 2009). In a New Zealand study reviewing patient records, adverse events were noted to affect 12.9% of hospitalised patients, which is costly for the health sector, and has a significant impact on patients and their families, often causing considerable pain and suffering (Brown et al., 2002). Most of these adverse events were avoidable, often occurring because of flaws in the way health services were organised (Brown et al., 2002). Gauld (2009) noted that a 2006 parliamentary select committee report estimated expenditure on errors to account for 30% of the New Zealand health budget. More recent New Zealand data published by the Health and Disability Commissioner (2016) revealed

failures in communication with patients, as the most common reason for complaints received about DHBs (42.0%) during a six month period from January – July 2016, closely followed by inappropriate treatment (37.9%), inadequate assessment (27.7%) and inadequate coordination of care (24.3%).

Patient safety, or the prevention of adverse events, is a unifying concern across different health professions, but remains a difficult and complex problem to solve due to differences in how it is perceived and implemented across different professional groups (Rowland & Kitto, 2014). The different discourses on patient safety across professional groups need to be brought closer together through the provision of supportive opportunities for them to learn together and enact quality improvement initiatives which are integrated into everyday practice (Rowland & Kitto, 2014; Wilcock, Janes, & Chambers, 2009). This view was reinforced in the recommendations in ‘To Err is Human’, which recommended the establishment of interdisciplinary team training using proven team training methods to promote patient safety (Kohn et al., 2000).

In order to be responsive to these calls, how health services are delivered and how health providers interact needs to change (Suter et al., 2012). Interprofessional practice and interprofessional education have a significant role to play because they are considered “an innovative strategy that will play an important role in mitigating the global health workforce crisis” (WHO, 2010, p. 10). Interprofessional practice impacts on service delivery by enhancing quality of care and creating efficiencies; and interprofessional education supports practitioners to interact and work effectively together in the delivery of high quality care (Suter et al., 2012). Yet, just how interprofessional education should best take shape and how it contributes to collaborative practice, improved health outcomes and workforce issues, needs further investigation and development.

Driver for change: Research evidence

After 50 years of enquiry, the World Health Organization and its partners acknowledge that there is sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice. (WHO, 2010, p. 7)

The 2010 WHO review of evidence with a focus on educating health professionals in some sort of integrated manner was important as it provided global guidance for interprofessional learning and collaborative approaches. However, some have argued there remains a lack of robust evidence to support actual sustained changes in collaborative practice, a reduction in healthcare costs, or an improvement in outcomes in

areas such as public health following interprofessional education, and advocate a more cautious approach (Brandt, Lutfiyya, King, & Chioreso, 2014; Zwarenstein, Goldman, & Reeves, 2009).

Nevertheless, the growing pool of studies in this area does point toward interprofessional education positively impacting on learner experiences, changing their attitudes, perceptions and understandings of other professions as well as attitudes toward collaborative practice (Cooper, Spencer-Dawe, & McLean, 2005; Darlow et al., 2015; B. Flood, McKinstry, Friary, & Purdy, 2014; Reeves et al., 2012). Not only are attitudes changed, but reports show an increase in collaborative knowledge and skills (Anderson, Thorpe, & Hammick, 2011; Reeves et al., 2016). More recently there has been a shift in researcher attention from these learner focussed and perception based studies to the impact of interprofessional education on a range of issues such as patient satisfaction and outcomes, patient safety and quality, performance in practice, health promotion and population health (Institute of Medicine, 2015; Reeves, 2016). These studies, though limited in number, have shown that pre-qualifying interprofessional education can prepare learners to work together in practice and have resulted in changes in behaviours and organisational practices with benefits for patients (Pollard, Miers, & Rickaby, 2012; Reeves, 2016; Reeves et al., 2016).

Research specifically investigating actual changes to practice and the associated outcomes that collaborative practice has on patient outcomes is slowly increasing, but there are continued calls for more evidence in this area (Cook, 2005; D'Amour et al., 2005; Institute of Medicine, 2015; Reeves et al., 2016; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013; Reeves et al., 2012; Zwarenstein et al., 2009). How to best educate learners able to enact and achieve these outcomes, and ways in which these can be measured, continues to be debated with further research required to test conceptual models of interprofessional education (Institute of Medicine, 2015).

International Perspectives on Advancing Interprofessional Education and Practice

Influential interprofessional discourses have emerged over the last two decades particularly in the UK, Canada, the USA, Scandinavia and Australia, at organisational, professional and educational levels. This in turn has prompted national engagement, raising the profile and providing a platform for interprofessional education and practice to become an integral part of the healthcare landscape (Kitto, Chesters, Thistlethwaite, & Reeves, 2011; Reeves et al., 2012). Just how interprofessional education and practice have taken shape has been dependent on national and international discourses, research

and dialogue. Searching the grey literature yielded a number of key, globally relevant, and significant reports which help to paint a picture of the current status and developments within the field (Frenk et al., 2010; Institute of Medicine, 2015; WHO, 2010, 2013).

A WHO international study group developed a framework for action on interprofessional education and collaborative practice that has had a significant impact on the direction of interprofessional education, practice and research in recent years (WHO, 2010). The framework was intended to provide policy and decision makers, health workers, managers and educators with ideas on how to take interprofessional education and practice forward within their current contexts. With this intention, it lays out the research evidence, provides examples of interprofessional learning in action, and strategies for achieving improved health outcomes through collaborative education and practice.

Concurrently, as the WHO interprofessional framework was being formulated, an independent Lancet Commission global report was produced by an international group of professional and academic leaders called *Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world* (Frenk et al., 2010). It was a shared and global strategy for transforming health education in response to the perceived complex challenges and changing demands discussed earlier. The main thrust of the report was to provoke thinking about how education could be transformed. Wide ranging recommendations specifically in relation to the structure and function of educational institutions, the learning and teaching processes involved, and the desired results or educational outcomes were made. These recommendations call for the health and education sectors to adopt core competencies, mobilise a wide range of learning pathways, incorporate interprofessional learning, as well as align professional accreditation and certification, enhance investment into health education, and strengthen opportunities for global learning, amongst others.

This initiative was followed by another WHO document aimed at transforming and scaling up health professionals' education and training as part of the WHO's programme to rapidly increase and prepare the health workforce (WHO, 2013). It supported the ideas that came out of the Lancet report by recommending new transformational approaches to health education. Approaches included community-engaged relevant curricula and both fostering and enhancing relational activity within and between education, health and other sectors (WHO, 2013). In their focus on transforming health education in order to improve and develop health practice, the Institute of Medicine in the United States, a

body with responsibility for examining policy matters pertaining to the health of the public, recognised the important role of interprofessional education in this endeavour (Institute of Medicine, 2015). They identified gaps in information pertaining to the outcomes of interprofessional education for patients, populations and systems, and recommended: closer alignment between education and the delivery of healthcare; a conceptual framework to assist in measuring the impact of interprofessional education; the strengthening of the evidence for interprofessional education; and better understanding its role in changes to collaborative behaviours (Institute of Medicine, 2015).

Key recommendations drawn from these reports include closer alignment and working relationships between health and education, better understanding of core competencies for interprofessional practice, frameworks to guide interprofessional collaboration, education and evaluation, and closer alignment of the professions. Against this global context, some of the many noteworthy developments specifically in Canada and the UK are discussed, followed by a reflection on New Zealand's position and the current status of interprofessional education and practice in this country.

Canada

In the early 2000s, a commission on the future of health care in Canada highlighted the importance of interprofessional education for patient centred care and recommended that health education programmes focus on integrated and team based care approaches, (Gilbert, 2014; Verma & Tassone, 2012). The intent was to change the healthcare culture in Canada from one of siloed health professional education and practice toward interprofessional education and practice (Herbert, 2005). In 2003 the Canadian government contributed between 60 and 80 million dollars to improve the planning and coordination of Health Human Resources, in which interprofessional education featured prominently (Gilbert, 2014; Herbert, 2005). The strategy developed by Health Canada to address these issues included a focus on “planning, recruitment and retention and interdisciplinary education for collaborative patient-centred practice. Concurrently, other funds have been made available ... to enhance interprofessional practice” (Herbert, 2005, p. 2). The Canadian Interprofessional Health Collaborative (CIHC) was one of a number of initiatives funded by Health Canada that provided a national hub for the leadership and support of interprofessional education and practice, which has been active in leading and supporting a range of interprofessional initiatives (CIHC, 2009).

There are many such initiatives, but I would like to draw attention to two notable developments that I believe have had wide reaching utility, relevance internationally, and impact on interprofessional education development in New Zealand. One was the University of British Columbia model of interprofessional education. It is a conceptual model developed on the premise that learners are at different stages of readiness for interprofessional education and have specific learning needs at different stages in the learning process. The model provides a tool for the management of learning (Charles et al., 2010). In the development of the model, a combination of theoretical perspectives were drawn on including human development, developmental theory, and transformative learning theory.

The second CIHC initiative was the development of an interprofessional competency framework that described core skills, knowledge and attitudes believed to represent the characteristics of an ideal interprofessional practitioner, the aim of which was to inform curriculum and professional development (CIHC, 2010). In arriving at these particular characteristics and developing the framework, the group drew on a range of literature as well as interprofessional and other health competency frameworks. They were mindful of the need to ensure the competencies provided a context from which to adequately prepare learners for situations they would encounter in practice. The interprofessional competencies identified as central to interprofessional practice include: client/family/community centred care, interprofessional communication, interprofessional teamwork, role clarification, conflict resolution, and interprofessional leadership (CIHC, 2010). In addition to the stated competency domains and outcomes, emphasis was placed on the processes necessary for the integration of the knowledge, skills, attitudes, and values inherent within the competencies (Interprofessional Education Collaborative Expert Panel, 2011). “Rather than focusing on demonstrated behaviours to determine competence, the framework relies on the ability to integrate knowledge, skills, attitudes, and values in arriving at judgments” (CIHC, 2010, p. 8). Despite the competencies being used to inform interprofessional curricula, the process of competency development has been described as challenging, which is believed to be attributed to the interprofessional field remaining not well understood (CIHC, 2010; Gilbert, 2014).

United Kingdom (UK)

In the UK, the Centre for the Advancement of Interprofessional Education (CAIPE), established in 1987, played a key role in integrating interprofessional education and

practice into the healthcare landscape. CAIPE consists of champions from health practice and education who have been instrumental in facilitating discussion about interprofessional education and practice within and outside of the UK. It has made significant progress in putting interprofessional education and collaborative practice on the agenda; contributing to policy and practice changes, with significant government investment to instigate and develop interprofessional education within the tertiary health education sector. A noteworthy change occurred in 2003, when the Health and Care Professions Council (HCPC) took over the regulation and registration of 16 health professions, excluding medicine, nursing and midwifery. The council set out a range of standards for practitioners to meet in order to remain on the register and be deemed fit for practice (HCPC, 2012). The HCPC professional standards include seven areas, covering the practitioners' character, health, conduct, proficiency, education, continuing professional development and prescribing. All of the standards, apart from those related to prescribing, are generic and apply to all of the health professions represented. In the standards relating to proficiency, generic standards are maintained but allow for flexibility in providing detail related specifically to that profession (HCPC, 2013). The establishment of common standards of behaviour and practice provided a platform for those charged with providing health education to consider developing programmes relevant across multiple professions, laying a platform for interprofessional learning. However, individual educational programmes were still subject to validation from their individual regulatory bodies, which has perpetuated differences between the professions (Barr & Helme, 2016). In the 2004 National Health Service (NHS) Improvement Plan, the UK Department of Health gave a clear mandate to health and education providers that "these programmes will achieve national coverage as we ensure that people learn together so they may better work together in the NHS" (Department of Health, 2004, p. 60). They went on to fund work which aimed to provide a coherent framework for the planning, delivery and evaluation of interprofessional education (Department of Health, 2007).

New Zealand

Much of the international discourse on interprofessional education and practice is pertinent to the New Zealand health and education sectors, particularly since interprofessional education is reported as the exception in New Zealand for the majority of its health professionals, with most still being taught separately (Fouche, Kenealy, Mace, & Shaw, 2014). In a study of interprofessional education across New Zealand and

Australian universities, the unanalysed data collected showed the majority of New Zealand universities reported they were using interprofessional education; however, there were significantly variable interpretations of just what interprofessional education constituted (Lapkin, Levett-Jones, & Gilligan, 2012). These authors concluded that there was very little formally structured interprofessional education actually occurring, and Australia and New Zealand fell short compared to interprofessional education in countries such as Canada and the UK (Lapkin et al., 2012). However Frenk et al. (2010) suggested that interprofessional education internationally had not kept pace with the challenges, attributing this to the largely fragmented and outdated curricula as evidenced by the continued teaching and learning in silos (Frenk et al., 2010). In a study of practitioners working in New Zealand chronic care environments Fouche et al. (2014) found many educational and practice gaps in interprofessional education in New Zealand, suggesting the need for more creative approaches to its development.

In the recent ‘refreshed’ New Zealand Health Strategy Future Directions (2016), the Health Minister reported overwhelming feedback from stakeholders on the “need for a greater focus on people, how to engage better in designing services together and how to better understand people’s needs” (MoH, 2016, p. ii). This was translated into what have been described as cornerstones in the development of health services which include four key notions: “people-powered, closer to home, value and high performance, one team and smart system” (MoH, 2016, p. ii). This recent strategy goes significantly further than previous health strategies in its call for ‘one team’, envisaged as collaborative and high trust teams that work to reduce fragmentation and “the barriers that currently prevent people from using their skills flexibly and fully” (MoH, 2016, p. 29). An ideal team is described as one that understands its role and the roles of others, has interagency collaboration in the provision of seamless or ‘joined-up’ care, and includes an authentic and people focussed leader (MoH, 2016).

The hallmarks of interprofessional practice have been consistently signalled in many national health strategy documents including The New Zealand Health Strategy (King, 2000; MoH, 2016), The New Zealand Disability Strategy (MoH, 2001), He Korowai Oranga: Māori Health Strategy (King & Turia, 2002), and the Sooner, Better, More Convenient Health discussion paper (Ryall, 2007). Despite this, there appears to be a lack of identifiable funding and explicit guidelines that would provide health practitioners, health educators and health planners with direction as to how to actually implement the ‘one team’ approach to care. As a result, interprofessional education in New Zealand,

although evolving, remains generally small scale, sustained by a few champions and delivered as discrete learning activities not embedded or well integrated into health curricula as a whole. This is a similar experience to that of the UK, where despite a realisation of the importance of interprofessional education for the preparation of a collaborative, mobile and responsive health workforce, “new wine was not to be put into old bottles” (Barr & Helme, 2016, p. 42). The reconciliation of new collaborative learning and practice expectations in the early 2000s with actual educational change was thwarted in the search for consensus amongst stakeholders (Barr & Helme, 2016).

The complexity and tensions inherent in the effective delivery of interprofessional care mean that simple solutions do not exist (Jones, 2000). Jones (2000), in a New Zealand study exploring a range of influences on team based practice, suggested that interprofessional education and a rebalancing of power must be developed in order to manage tensions and overcome intra-organisational and inter-organisational conflicts and barriers. Despite realisation of the importance of interprofessional education and practice in New Zealand, and calls for its implementation (Fouche et al., 2014; Lapkin et al., 2012; Ministry of Health, 2016), its development remains largely informed by international studies, with limited local research.

Current status

In those countries where interprofessional education and practice has been embedded into the health and education landscapes, a multipronged approach to its development appears to have been taken. With strong champions leading the charge, evident in the UK with the establishment of CAIPE and in Canada with the CIHC, there have been some significant gains in interprofessional education and collaborative practice including: the conceptualisation of interprofessional education frameworks which support the development of learning activities such as the UBC Interprofessional Education Model and the Institute of Medicine Interprofessional Education Model; the standardisation of some key regulatory frameworks with the amalgamation of common competencies/standards across a large number of the regulated health professions through, for example, the HCPC in the UK; and the negotiation of interprofessional competencies for interprofessional practice such as the Canadian Interprofessional Competencies (CHIC, 2010). In addition, a clear mandate and funding have gone some way to creating mechanisms for tertiary health education providers to embed interprofessional learning into curricula, although this remains problematic.

In spite of these gains and the progress made in the last few decades, Thistlethwaite, Jackson, and Moran (2013) argued that much of this work has been cosmetic, with just enough done to meet patient needs and to satisfy regulatory bodies. Calls to better prepare practitioners to become ‘collaborative and practice ready’ continue (WHO, 2010). These calls question how future and current health practitioners can best learn to communicate and collaborate while concurrently developing attitudes and qualities necessary to deliver caring, compassionate, people-centred care in collaborative environments. Characteristics such as “leadership qualities and respect for others’ cultures” (Institute of Medicine, 2013, pp. 2-1), and “caring, compassionate and committed staff, working within a common culture” (Francis, 2013, p. 85) are needed for a team who “understand each other’s roles, core competencies, basic language and mind-sets, and ... develop attitudes and behaviours that facilitate collaboration” (WHO, 2013, p. 23). The development of collaborative ways of being enables them to “mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams” (Frenk et al., 2010, p. 2).

In addition to recognition of the types of characteristics or qualities needed for effective interprofessional collaboration, the importance of where, when and how these are best developed and sustained across the education-practice continuum has also been highlighted. The Institute of Medicine, WHO and others have called for greater collaboration and coordination between the health and education sectors, and between policy makers and health system leaders, which is considered a prerequisite for optimal learning and for the development of an effective collaborative ready health workforce (Frenk et al., 2010; Gilbert & Rose, 2016; Institute of Medicine, 2015; WHO, 2010). The interdependent relationship between education and health practice is considered central to the imprinting, application and sustainability of collaborative practices and needs to be better aligned (Institute of Medicine, 2015). Calls for the urgent development, adoption and evaluation of comprehensive theoretical models of interprofessional learning which address the complexities inherent in the field in order to guide learning and research have also been made (Gilbert & Rose, 2016; Institute of Medicine, 2015; Suter et al., 2012; WHO, 2010; WHO, 2013).

Interprofessional Education Development

As discussed above, developments in interprofessional education have occurred internationally in direct response to the recognised need for greater interagency

collaboration and interprofessional practice (Cooper, Braye, & Geyer, 2004), which is increasingly called for in a healthcare environment where health professionals are confronted with new demands and expected to continuously transform their practice (Eriksen, 2015). Achieving the necessary depth and breadth of understanding to adequately inform these rapid interprofessional developments still appears to be a challenge. Professional status, power, rivalry, tribalism, siloed practices and the ongoing difficulties gaining consensus amongst stakeholders, as well as the limited evidence and theoretical base and the complexities in the delivery of interprofessional education and practice are amongst the challenges encountered in developing and sustaining interprofessional education (Barr & Helme, 2016; Nisbet, Hendry, Rolls, & Field, 2008; Reeves et al., 2011). The role and impact of the hidden curriculum (Thistlethwaite, 2014; Thistlethwaite et al., 2013) and the potentially narrow view with which interprofessional competencies are used, may also act to limit or inhibit the development of the attributes or qualities necessary for becoming or wanting to become interprofessional (Talbot, 2004). There is no doubt that the diversity and complexity inherent within this field perpetuates the difficulties in answering these challenges. Some have argued that rapid developments in this area, although understandable, are risky, especially without a sound theoretical base or locally generated strategies for ensuring effectiveness (Craddock, O'Halloran, Borthwick, & McPherson, 2006). The limited use of theory was highlighted in a scoping review undertaken by Reeves et al. (2011), which looked to identify key interprofessional concepts and theoretical perspectives in the interprofessional literature. The lack of a theory driven and systematic approach has resulted in some interprofessional education strategies employed within institutions not yielding the planned results with some failing to thrive in the long term (Suter et al., 2013). Although this may present a worrying picture, it is not necessarily an indication of the lack of effectiveness of interprofessional education (Barr, Hammick, Koppel, & Reeves, 1999; Cook, 2005). There continues to be sustained growth in the use of theory and conceptual frameworks to underpin and support interprofessional education, practice and research (Reeves, 2016).

Toward interprofessional socialisation

In response to the complexities and speed with which interprofessional learning and practice has developed in recent years, leaders in the field have suggested achieving successful organisational change will require a more radical approach that challenges the prevailing views acting as barriers (Ginsburg & Tregunno, 2005). In such an approach,

interprofessional education would be reconceptualised as a process instead of an intervention (Olson & Bialocerkowski, 2014). One way of achieving this is through the development of interprofessional strategies and aligned experiences that focus instead on interprofessional socialisation. Such a process would challenge power differentials between professions and the influence of traditional siloed educational approaches. Opportunities for interprofessional socialisation are considered essential for breaking down barriers, facilitating role learning, and developing a dual identity for interprofessional collaborative practice (Clark, 2006; Khalili, Orchard, Spence Laschinger, & Farah, 2013).

Even with growing recognition of the value of interprofessional education and practice in improving health systems and health outcomes and despite the educational system being considered “one of the main determinants of interprofessional collaborative practice, because it represents the principal lever for promoting collaborative values among future health care professionals” (San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005, p. 137), health professionals are predominantly educated within their professions. To this day tensions remain between discipline-specific and interprofessional learning (Khalili, Orchard, Laschinger, & Farah, 2013). Professional socialisation is a process by which people become members of a particular profession and acquire the knowledge, language, values, beliefs, norms and expected behaviours of that profession (Cribb & Gewirtz, 2015; Khalili, Hall, & DeLuca, 2014; Khalili, Orchard, Laschinger, et al., 2013; Sharpe & Curran, 2011; Stanley, Dixon, Warner, & Stanley, 2016). Educational experiences where students in one discipline primarily learn in isolation from other disciplines, act as barriers to interprofessional collaboration and produce health professionals who continue to work in silos (Hall, 2005; Khalili, Orchard, Laschinger, et al., 2013; Swisher, 2009). Such socialisation processes solidify their profession's unique view of the world and their uniprofessional identity (Hall, 2005; Khalili, Orchard, Spence Laschinger, et al., 2013). The student experience of these practices is thought to “foster relationships based on power, competition and hierarchies, resulting in inadequate preparation for teamwork” (Margalit et al., 2009, p. 166), with the strength of professional cultures perpetuating stereotypes, professional rivalry, power imbalances between disciplines, and creating difficulties in working effectively as part of a team. A study of undergraduate physiotherapy and podiatry students' stereotypes of each other's professions before and after interprofessional education, reported that preconceived stereotypes were formed even before the students entered health education programmes (Mandy et al., 2004). This contributed to the development of strong

professional identities, such that “deep-rooted prejudices and professional ‘territoriality’ challenge successful integration of disparate views and represent a significant barrier to interprofessional collaborative care” (Chung et al., 2012, p. 32). Until these stereotypes and worldviews change, the ability of the learner to see things differently will be difficult to achieve (Ginsburg & Tregunno, 2005).

Interprofessional socialisation is an approach that may well work to overcome some of the barriers identified as inherent within current educational practices. It is a process whereby learners come together to learn from, with, and about one another, are socialised into the interprofessional team, and are able to bring uniprofessional and interprofessional worldviews together (Clark, 2006; Khalili, Orchard, Spence Laschinger, et al., 2013; Stanley et al., 2016). Interprofessional socialisation enables the development of both a distinctive profession oriented and an interprofessional identity, which in effect is a dual identity (Khalili, Orchard, Spence Laschinger, et al., 2013). Interprofessional socialisation enables a blending of worldviews to create a workforce with a greater understanding and capacity to work collaboratively in the provision of well informed and patient centred care and needs to be a reflective process (Eriksen, 2015). The shift to incorporate an interprofessional worldview requires a transition that involves the letting go of the known and embracing the new, particularly for academics and practitioners schooled in the traditional models of health education (Colyer, 2008). Interprofessional education as part of a process of interprofessional socialisation “may be better understood as an emergent property of the embodied connections, negotiated healthcare decisions and reflective actions among people, processes and things” (Radomski & Beckett, 2011, p. 89) rather than activities that are discreet, linear, pre-planned, coordinated and structured in advance.

It has been suggested that team based learning should be integrated into the socialisation process as part of a continuum of learning which needs to be valued and incentivised so that it becomes embedded (Frenk et al., 2010). Being able to develop and embed an interprofessional socialisation process and a sustainable interprofessional education programme across multiple health professions requires an innovative and more encompassing educational change approach. Such an approach means the learning and practice from, with and about others is recognised as socially situated and relational, where those involved in interprofessional encounters think and act socially in response to unknown or unplanned events (Radomski & Beckett, 2011). It is an approach where professional socialisation sits alongside this notion of interprofessional socialisation as

dual identity formation (Khalili, Orchard, Spence Laschinger, et al., 2013) and where there is an opening up of more reflexive spaces for interprofessional ‘thinking’ related to the real world ‘doing’ of interprofessional practice (Radomski & Beckett, 2011). The interprofessional thinking of such an approach moves learners toward a more fluid and dynamic way of working, one that prepares them for the complexities of practice that go beyond the planned and known, requiring a cultural shift that is conducive to collaborative practice (Radomski & Beckett, 2011; Stanley et al., 2016).

Toward Understanding the Phenomenon of Interprofessional Practice to Inform Interprofessional Learning

The Lancet report (2010) on transforming health professional education highlighted the importance of the relevance, timing and duration of interprofessional education programmes that are able to respond to the local contexts with increasingly complex and interdependent health systems and populations (Frenk et al., 2010). Ensuring relevance and fit with the local context was highlighted by Hammick, Freeth, Koppel, Reeves, and Barr (2007), who stated that customising interprofessional learning to reflect the realities of practice acts as a mechanism for ensuring positive outcomes. Development of relevant and realistic interprofessional learning requires not only insight into the realities of practice but a high level of collaboration and co-operation between health workforce planners and those tasked with providing health education, in order to facilitate sustainable interprofessional education (Thistlethwaite, 2012; WHO, 2010).

The significant increase in published interprofessional research in a wide range of journals over the past 40 years has contributed to the legitimacy of the field (Paradis & Reeves, 2013; Reeves, 2016). Notwithstanding this, leaders in the field recognised that much of the interprofessional research was based on small scale and short term studies, where there was a limited grasp of the complexity, culture, and language inherent in interprofessional interactions (Reeves, 2016). The complex elements needed to achieve effective interprofessional collaborative practice, teamwork and decision-making mean that examples in the research literature are difficult to find (A. J. Wilson, Palmer, Levett-Jones, Gilligan, & Outram, 2016). More recently, studies have begun to utilise interview data to ensure greater breadth and depth, but there remains a limited focus on actual interprofessional interactions occurring in practice (Reeves et al., 2016; Reeves, Palaganas, & Zierler, 2015).

Although research of health professionals’ experiences and perspectives of interprofessional collaboration and the resulting implications for practice, research and

education appears to be increasing, Smythe (2011) noted that there is often a ‘feast’ of literature related to a topic area, yet a ‘famine’ of anything related to the experience itself. Existing bodies of scientific knowledge and our common sense pre-understandings and assumptions “predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question” (van Manen, 1990, p. 46). By increasing our awareness of the phenomenon of interprofessional practice, gaining a deeper understanding of how it is experienced by health professionals by exploring their opinions, perceptions and understandings of it, insights may be brought forward which better inform the development of localised, relevant and needs-driven interprofessional learning into the future.

Continuing to expand scholarship and ensuring there is good evidence for the interprofessional activities that are created and implemented is an important task for those involved (Paradis & Reeves, 2013). Qualitative research has been recognised as providing rich sources of information (Cooper, Carlisle, Gibbs, & Watkins, 2001), important because of its role in deepening understandings in relation to the complexities and nature of interprofessional practice (Zwarenstein & Reeves, 2006). There is appreciation for the use of qualitative studies in interprofessional research, which allows more detailed understandings of unique individual and group experiences, which then forms the basis for policy change and the development of innovative interventions (Wener & Woodgate, 2013). The role of phenomenological research in promoting understanding, and its role in informing health planners prior to the allocation of resources, was noted by Annells (1996): “Phenomenological research is eminently suitable for seeking understanding about phenomena of vital importance ..., but that in health care funding to spend trillions without reflection as to meaning is utter foolishness, if not insanity” (p. 709).

Van Manen (2014) suggested that phenomenology as a research method

respects the thing in its whatness and in its otherness...Phenomenology must stand in awe at the wonder of the thingness of the thing as it acquires its meaning in relation to the other things that surround each other in the world. (p. 52)

Supporting research that respects and reflects on the thing in its whatness, and the meanings that surround it may work to inform interprofessional learning development. Such understandings are particularly pertinent, given that interprofessional team-based and collaborative approaches underpin many national and international policy and practice directives, as well as much of the health and education resources being invested in this area.

Health practitioners' experience of working with others

To be interprofessional has been described as involving thinking, feeling and the actual doing of interprofessional practice (Hammick et al., 2009). Learning how interprofessional practice is experienced by those involved in the 'thinking, 'feeling' and 'doing' is important both to further inform and enhance practice, and also education. The lived experience, as suggested by van Manen (2014), "forms the starting point for inquiry, reflection, and interpretation" (p. 40).

The studies that inform the discussion below have come from a diverse pool of literature that added to its richness. This diversity is evident in the varied practice contexts, the range of professional groups involved and the countries where these studies took place. The following examples have been given to provide a flavour of this diversity and include a Belgium study of general practitioners' experiences and preferences of interprofessional collaboration within palliative care environments (Pype et al., 2013). An Australian study sought a range of health professionals' experience of collaboration in rehabilitation teams (Crocker, Trede, & Higgs, 2012). Experiences and challenges of an interprofessional community of practice in HIV and AIDS care by stakeholders was undertaken in South Africa (Doriccah Peu et al., 2014). In America, the nurse-doctor experience of collaboration was explored within aged care facilities (J. L. O'Brien, Martin, Heyworth, & Meyer, 2009). Another aged care study explored the experiences of collaboration amongst Swedish health workers in home based care environments (Larsen, Broberger, & Petersson, 2016). A study exploring the collaborative experiences of staff working in mental health environments who were applying cognitive milieu therapy for inpatients with dual diagnosis was undertaken in Norway (Borge, Angel, & Røssberg, 2013), while a Canadian study looked at interprofessional collaboration within primary healthcare teams involving a number of professional groups (Goldman, Meuser, Rogers, Lawrie, & Reeves, 2010). New Zealand also featured with a study exploring interprofessional collaboration and the differences in practice between nurses and doctors within hospital based services (Barrow, McKimm, Gasquoin, & Rowe, 2015). Finally, a UK based study explored the collaborative experiences of nurses, doctors and pharmacists in relation to medication safety (A. J. Wilson et al., 2016). This illustrates the diversity of the people and contexts captured within these studies.

All of the studies included encompassed experiences of working with others as a significant part, although not all had health professionals' experiences of interprofessional collaboration as the main focus. Whilst still capturing practitioner

experience of collaboration, the researchers considered various aspects of collaboration such as the impact of undergraduate education on health practitioner experience of and ability to engage in teamwork (Veerapen & Purkis, 2014), the complexity of interprofessional working (Hood, 2015), nurses' experiences of their role in interprofessional teams (Schwartz, Wright, & Lavoie-Tremblay, 2011), new graduate nurses' confidence of working interprofessionally (Pfaff, Baxter, Jack, & Ploeg, 2014) and the experience of working in a newly formed interprofessional team (Moe & Brataas, 2016).

Another aspect of the richness within the studies was that all of them were qualitative, or included a qualitative component in the case of the mixed methods studies, of which there were two. The majority utilised qualitative descriptive methodologies, however studies also reported using hermeneutic phenomenology, grounded theory and case study approaches. All employed interviews and/or focus groups. Reading across the 28 studies that appeared most relevant, there was a clear focus on aspects that either facilitated or constrained collaboration. Authors recognised that collaboration and the context within which it occurs contributes to the provision of care for their patient groups and that drawing on experience would provide insights to inform the development of better working and learning practices.

Approaching the studies thematically enabled the drawing together of aspects identified as important in the practitioners' experience of the interprofessional encounter. These aspects were grouped into three broad themes; knowledge and skills, values and attitudes, and organisational and contextual features. However, the being and doing of interprofessional practice, which involves knowledge and skills, values and attitudes as well as organisational and contextual aspects, were not experienced in isolation. In all studies, aspects were revealed from each of the three themes that illustrate their interrelatedness and interdependence.

Skills and knowledge

Knowledge and skills included those more measurable or quantifiable characteristics or competencies. One common feature identified by practitioners as important for collaborative practice was role understanding; the knowing of and about the roles and responsibilities of others (Cioffi, Wilkes, Cummings, Warne, & Harrison, 2010; Ebert, Hoffman, Levett-Jones, & Gilligan, 2014; Glaser & Suter, 2016; Harrod et al., 2016; Hellman, Jensen, Bergström, & Brämberg, 2016; Hood, 2015; Morris & Matthews, 2014;

Pype et al., 2013; Thomson, Outram, Gilligan, & Levett-Jones, 2015). Understanding each other's roles might be described in terms of understanding what tasks others perform and how that is done on a day to day basis and as fundamental to collaborating (Harrod et al., 2016). Alternatively, it might be observed in its absence, as impeding health practitioners' ability to work at full scope, collaborate and contribute to teamwork (Ebert et al., 2014; Glaser & Suter, 2016).

Being able to communicate effectively within a team environment is a skill identified as critical for effective interprofessional collaboration (Cioffi et al., 2010; Croker et al., 2012; Hood, 2015; Moe & Brataas, 2016; J. L. O'Brien et al., 2009; Parker Oliver & Peck, 2006; Pype et al., 2013). Dialogue was identified as a basic social process, one that a study by McCallin (2004) suggested was "the essence of successful interdisciplinary working" (p. 28). This is further supported when there is an understanding, respect and a valuing of others roles, responsibilities, and unique contribution (A. J. Wilson et al., 2016). Interprofessional education is recognised as fundamental for the preparation of graduates with the necessary knowledge and skills to work collaboratively and communicate effectively within interprofessional teams (A. J. Wilson et al., 2016).

In addition to role understanding and good communication skills, being competent, able to reflect on practice and demonstrate effective interpersonal skills were thought to directly influence good interprofessional collaboration (Barrow et al., 2015; Hellman et al., 2016; J. L. O'Brien et al., 2009; Parker Oliver & Peck, 2006; Pype et al., 2013). The need for the continual nurturing of collaboration and the support of one another is fundamental to developing and sustaining effective interprofessional interactions for all, but especially new graduate health practitioners (Hellman et al., 2016). Competence develops over time, and making the transition from student to practitioner is a time when new graduate "incompetence and unpreparedness is humiliatingly visible and their sense of self frequently violated" (Veerapen & Purkis, 2014, p. 223).

Organisational and contextual features

The possibility of practitioners to employ their interprofessional knowledge and skills was questioned if the organisational context where this practice was taking place was not supportive. "It will therefore not be enough for practitioners to develop ... or to learn generic 'competencies' for interprofessional working, unless these ... skills are deployed in a working context that encourages innovative and adaptive solutions" (Hood, 2015, p.

151). Organisational and contextual features significantly impact on practitioners' ability to engage in and sustain effective interprofessional practice.

Supportive leadership and coordinated, fluid and flexible systems for effective interprofessional collaboration were recognised as important in enabling the establishment of a collaborative culture to take hold (Cioffi et al., 2010; Goldman et al., 2010; Harrod et al., 2016; Hood, 2015; Larsen et al., 2016; Laurenson & Brocklehurst, 2011; Parker Oliver & Peck, 2006; Pype et al., 2013; Rubio-Valera et al., 2012; Sommerseth & Dysvik, 2008; Veerapen & Purkis, 2014). A culture was described as one that prioritised sufficient time and space for collaboration to occur (Cioffi et al., 2010; Goldman et al., 2010; Harrod et al., 2016; Hood, 2015; Pfaff et al., 2014; Rubio-Valera et al., 2012), where there were common team goals, opportunities for collaborative decision making, role blurring and shared accountability across the team (Borge et al., 2013; Cioffi et al., 2010; Hood, 2015; Merrick, Fry, & Duffield, 2014; Moe & Brataas, 2016), and one where there was a shared and consistent approach to care that was patient centred as opposed to profession-focused (Sommerseth & Dysvik, 2008; Thomson et al., 2015). A lack of a patient centred approach, a limited understanding of the roles and cultures of other professions, and a focus on biomedical approaches to care all contributed to the absence of collaborative teamwork (Sommerseth & Dysvik, 2008). The studies referred to above have argued that for collaboration to take hold, practice focus needs to shift toward the patient, and include good leadership and a supportive system.

The impact of workplace demands appeared to heighten professional differences and hierarchy, which acted as barriers for interprofessionalism and leadership, and remained an ongoing issue for the development and sustainability of interprofessional working (Barrow et al., 2015; Laurenson & Brocklehurst, 2011; Parker Oliver & Peck, 2006; Pype et al., 2013; Veerapen & Purkis, 2014). Issues related to perceived and experienced professional difference that arose during the respectful and knowledgeable exchange of information between nursing and medicine, included hierarchy, competence and contextual factors (Barrow et al., 2015). Rigid professional boundaries and hierarchies contributed to a fear of speaking out, reluctance to question and an emphasis on individual rather than collective/team responsibility (Thomson et al., 2015). A focus on the merging of professional identities between team members, with team members coming to understand their profession and the ways in which they become a member of that profession, as well as the complexities inherent in the practice world, are all

important considerations in reducing hierarchy and managing professional differences in order to promote collaborative practice (Barrow et al., 2015). However, acknowledging professional differences is an important first step to opening up further dialogue and beginning to address differences within the team (Laurenson & Brocklehurst, 2011).

The need to re-vision professional roles as complementary, as opposed to competitive, was particularly evident in new and emerging areas of practice where the need to rethink and renegotiate traditional healthcare roles and scopes of practice was identified as a critical success factor (Goldman et al., 2010; Veerapen & Purkis, 2014).

The provision of opportunities for interprofessional education and team building was identified by many as integral to interprofessional practice (Cioffi et al., 2010; Goldman et al., 2010; Moe & Brataas, 2016; Parker Oliver & Peck, 2006; Schwartz et al., 2011; Veerapen & Purkis, 2014; A. J. Wilson et al., 2016). However, despite the workplace environment and its culture and practices arguably setting the scene for collaboration, it can either work to build on or dilute undergraduate interprofessional education experiences (Veerapen & Purkis, 2014).

Values and attitudes

The values and attitudes revealed in the studies included those aspects difficult to measure or quantify. These aspects are more often related to who the person is and their personal qualities reflecting the interpersonal nature with which the person engages in the interprofessional collaborative encounter (Croker et al., 2012).

Some of the core values that emerged as important from these studies included the notions of trust, respect and a valuing of others, which many of the practitioners in the reviewed studies identified as central to effective interprofessional collaboration (Borge et al., 2013; Cioffi et al., 2010; Croker et al., 2012; Doricah Peu et al., 2014; Hellman et al., 2016; Larsen et al., 2016; Merrick et al., 2014; Moe & Brataas, 2016; Morris & Matthews, 2014; Oliver, Tatum, Kapp, & Wallace, 2010; Schwartz et al., 2011; A. J. Wilson et al., 2016). Sometimes trust became evident when it was lacking, which can have wide reaching implications; impacting a practitioner's ability to actively engage with the team (Doricah Peu et al., 2014). Trust does not sit on its own, but is built over time, enabling practitioners to move toward being more active team members (Schwartz et al., 2011).

The building of trusting relationships was fostered when there was a focus on the patient and his/her needs (Larsen et al., 2016) and, along with feeling valued and respected by

other team members, enabled practitioners to integrate and feel part of the interprofessional team (Cioffi et al., 2010; Croker et al., 2012; Hellman et al., 2016; Larsen et al., 2016; Merrick et al., 2014; Moe & Brataas, 2016; Pfaff et al., 2014; Pype et al., 2013; Rubio-Valera et al., 2012; Schwartz et al., 2011; Thomson et al., 2015). Trust formed the foundation for a safe working environment which, along with access to supportive relationships and opportunities for collaboration, increased the confidence of new graduate nurses engaging in interprofessional teams (Pfaff et al., 2014). Feelings of trust and security came when relationships between team members were prioritised and, when these trusting relationships were formed, opportunities for collaborative decision making and dialogue were enhanced (Larsen et al., 2016; Merrick et al., 2014). Respect was integral to practitioners being able to engage in the team and, along with a supportive team, facilitated new graduate nurses' confidence in interprofessional collaboration (Croker et al., 2012; Pfaff et al., 2014).

Interprofessional practice requires a team identity, shared team goals, understandings, and values, which have been described and encapsulated as an interprofessional worldview (Borge et al., 2013; Croker et al., 2012; Hellman et al., 2016; Laurenson & Brocklehurst, 2011; Moe & Brataas, 2016; Oliver et al., 2010; Thomson et al., 2015; Veerapen & Purkis, 2014). Embedded within the notion of an interprofessional worldview is the notion of a collaborative attitude (Borge et al., 2013; Croker et al., 2012; Sommerseth & Dysvik, 2008; Veerapen & Purkis, 2014) – an attitude which remains positive, responsive and open to others' differing perspectives and skills (Croker et al., 2012; J. L. O'Brien et al., 2009). Preconceptions and stereotypes can create barriers to a collaborative attitude, driving generalisations, ineffective communication and behaviours that can promote conflict within the team (Thomson et al., 2015; Veerapen & Purkis, 2014). Stereotypes pervade interprofessional interactions and work to block attempts to explore and address them (McCallin, 2004).

The consistent messages of experience

Despite the fact that some of these studies may not be strong in their own right, or labelled 'low level' from a scientific/positivistic perspective, when pulled together there is consistency in the messages of what is experienced in practice. This consistency comes despite the diverse places, contexts, teams and methodologies employed, making these written accounts informative for this study.

The multifaceted and complex nature of working with others was seen when experiences of interprofessional practice were explored. Participants' mood, preunderstandings, previous experiences and their interprofessional context influenced their experiences and how they understood, interpreted, felt and responded. The multifaceted nature of interprofessional practice, and the ways in which it is understood by practitioners, would appear to align with the current state of the interprofessional field, where differing understandings and perspectives remain and where it has been difficult to find a unifying or common way to understand, explain or prepare practitioners for this way of working. Despite these differing understandings and experiences, consistent features common across different professions and contexts have been illuminated.

Across all the studies reviewed, there was an implicit recognition of the complexity and relational nature of interprofessional practice and the important role of interprofessional learning in supporting current and future practitioners to work collaboratively. Opportunities for interprofessional education that position reciprocity, trust, respect and valuing one another at the forefront were widely recognised as integral to effective interprofessional practice in the studies (Barrow et al., 2015; Ebert et al., 2014; Hellman et al., 2016; Hood, 2015; Schwartz et al., 2011; Veerapen & Purkis, 2014; A. J. Wilson et al., 2016). Studies point toward providing educational approaches that focus on the patient, recognise the contribution of the practitioner as a person, the merging of professional identities, the building of respectful and trusting relationships across professional boundaries through dialogue, and the creation of safe learning environments (Barrow et al., 2015; Cioffi et al., 2010; Croker et al., 2012; Doricah Peu et al., 2014; Ebert et al., 2014; Hellman et al., 2016; Laurensen & Brocklehurst, 2011; Morris & Matthews, 2014; Pfaff et al., 2014; Schwartz et al., 2011). Education needs to enable learners to see the benefits of working interprofessionally, and actively learn to embrace it (Laurensen & Brocklehurst, 2011).

Creating a culture which supports, and is inclusive of, interprofessional socialisation processes and activities has been identified as necessary in working toward addressing the issues (Stanley et al., 2016). Authors argue for a culture which aims to “produce an entirely different graduate; one prepared *not only* to engage in exemplary discipline-specific practice *but also* participate and lead as a member of an interprofessional team” (Pardue, 2013, p. 98). Lennox and Anderson (2012) argued that for the preparation of a workforce able to achieve quality outcomes, there is a need to complement the development of discipline specific and technical skills with those required for effective

team working and collaborative practice. Interprofessional education is well placed to develop those features related to both knowledge and skills, and values and attitudes, but “however much we advocate for interprofessional working and team-based care, policy and resources are required for optimal functioning” (Thistlethwaite, 2016, p. 1082) in both the education and health sectors. As noted by Hood (2015), the attainment of knowledge, skills, values and attitudes devoid of a supportive and nurturing context and culture is not sufficient for the complex task of collaboration. This is the challenge that the literature sets for interprofessional education: to educate current and future health practitioners with the skills and knowledge, and values and attitudes to be able to work effectively within supportive interprofessional contexts.

Competencies as a Predominant Mechanism in Interprofessional Education

Although opportunities for interprofessional learning, both formal and informal, are seen by the WHO (2010, 2013) as a necessary step in preparing a workforce that is collaborative and practice ready, debate will continue about the meaning and processes of interprofessional education and practice (The Interprofessional Curriculum Renewal Consortium, 2013). Interprofessional education is not a homogenous field, but covers a wide variety of activities which vary in duration, the disciplines involved, the target audience and the pedagogical approaches used (Payler, Meyer, & Humphris, 2008). Notwithstanding calls for a theoretical framework or a more unifying model of interprofessional education that identifies major interprofessional concepts, learning outcomes, assessment methods, educational activities and tools to evaluate educational outcomes (Clark, 2006; Institute of Medicine, 2015), some have argued that a single theoretical approach would be insufficient in such a complex field (Hean, Craddock, & Hammick, 2012).

The predominant pedagogical approaches to interprofessional education and higher education in general have been based on and driven by competency frameworks (Dall’Alba & Barnacle, 2007; Lingard, 2009). These general frameworks have focussed on the individual and the development of an autonomous and ‘competent’ practitioner (Lingard, 2009). The competencies identify what professional competence looks like, provide consistent standards, outline specific performance indicators for successful achievement of the particular competency (Hepp et al., 2015) and, in relation to interprofessional competencies, provide a common lens through which different disciplines can understand and implement collaborative learning activities (Thistlethwaite et al., 2014). Interprofessional competencies are commonly understood

as shared knowledge, skills, values and attitudes, that can only effectively be achieved through interprofessional education (Thistlethwaite et al., 2014). However it would appear that a lack of agreement remains in what the meaning of a competency is (Reeves, Fox, & Hodges, 2009; Roegiers, 2007) and how this is being translated and implemented in health education. All too evident in this view is that “a slow burning crisis is emerging in the mismatch of professional competencies to patient and population priorities because of the fragmentary, outdated, and static curricula producing ill-equipped graduates from underfinanced institutions” (Frenk et al., 2010, p. 4).

That competency based approaches are variously understood in terms of the lack of agreement and understanding of its meaning, and indeed what it might constitute, is highlighted in a question posed by Lingard (2009). She asked, “what aspects of competence are we attending to, and what aspects are we avoiding?” (p. 625). It is accepted that competencies contain knowledge and skills, but agreement on what the other components look like and how they are utilised is lacking (Fernandez et al., 2012). Talbot (2004) warned of the dangers of “being subsumed in a minimalist discourse of competency” (p. 587) and others caution that, despite the advantages of recognising acceptable performance requirements, competency based practices in this area can limit innovation, maintain conventional practices and interfere with collaborative practice; they call for a wider, critical debate (Reeves et al., 2009). However, Roegiers (2007) suggested that competencies are misunderstood and hampered by misconceptions:

Of course, education must continue to instil knowledge and to teach how to think, but it must above all teach how to ‘take action’... carefully reflected action, responsible action and civic-minded action, founded on the principles of sharing, of solidarity and of sustainable development. (p. 157)

Given the nature of interprofessional practice, the continued calls for better prepared and collaborative health workers, the different understandings of the important attributes and qualities required to become effective interprofessional practitioners, the ongoing challenges in the development, delivery and evaluation of interprofessional education, and the challenges with sustaining these ways of learning and working, one may justifiably ask how the field makes sense of it all and moves forward?

Summary

Interprofessional learning and practice has been described as a “wicked problem” (Gilbert & Rose, 2016, p. v); that is, one that is complex and often impossible to solve,

with solutions dependent on what is known, always incomplete and changing, and often based on contradictory information. Despite clear calls for, and evidence of, collaborative practices impacting positively on health outcomes and health systems, a wicked problem remains. It is a wicked problem because of the complexity that comes with attempts to bring diverse professional groups together, because of challenges translating the research base into practice, fuelled by the lack of agreement on a unifying approach or framework from which to view and guide its implementation. It is a wicked problem because of the varied contexts and populations in which it is required.

Through a conversation with the literature, which was informed by the fore-meanings brought to this review, I have presented a particular view of interprofessional education and practice that I believe has highlighted just what a wicked problem it is. Understanding more about the phenomenon of interprofessional practice by those engaged in it may generate greater understandings about what is important in this area for practice and for education. The notion of interprofessional socialisation emerged as a way of overcoming some of the challenges of working between and among the professions, that may also allow the personal qualities revealed such as trust, respect, confidence and wanting to work in this way to flourish.

My exploration of the literature has left me with some questions. I feel there remains a gap in understandings of what lies beneath ‘good’, or is at the ‘heart’ of, interprofessional practice, with more information needed to help form a more complete understanding. What things show themselves as important in the doing and being of interprofessional practice? What makes interprofessional practice good? And lastly, how can a greater understanding of the lived experience of interprofessional practice inform the approaches and conceptualisation of interprofessional education into the future?

CHAPTER THREE

METHODOLOGY

Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations—and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect.

(van Manen, 2007, p. 12)

Introduction

van Manen (1990), drawing on the thinking of Husserl [1859-1938] and work of Rorty (1979), discussed the importance of reflecting on the nature of events as experienced in everyday life. He suggested such pondering on ‘everydayness’ can contribute to our awareness, thinking, insight and ultimately our ability to act with tact and thoughtfulness. The methodological approach of this thesis seeks to explore how interprofessional practice is experienced in ‘everyday’ practice by those engaged in providing healthcare. Further, this study looks to question, uncover and gain a sense of understanding of how the world is experienced by health care professionals in relation to interprofessional practice. The quest is to ask what can be learnt from these experiences that may help to better prepare future healthcare practitioners able to work with tact and thoughtfulness in complex, interprofessional contexts.

The nature of my research question drew me to the philosophy and methodology of hermeneutic phenomenology, informed by the particular perspectives of Martin Heidegger [1889-1976] and Hans-Georg Gadamer [1900-2002] to provoke my thinking and inform my interpretation. Elements that surfaced in thinking and deliberating on the phenomenon in question affirmed this philosophical and methodological direction. This was largely a response to the multifaceted and dialectical nature of interprofessional practice and the multiple levels of meaning inherent within it, which meant that a focus on a single dimension would not provide an account able to capture its essential meanings (Lynam, Browne, Reimer Kirkham, & Anderson, 2007).

The following discussion seeks to show the relationship between the research question, the philosophy and the use of hermeneutic phenomenology. Relevant philosophical notions drawn from both Heidegger and Gadamer will be outlined to illustrate the ways these concepts have advanced my understanding of interprofessional practice.

Philosophical Underpinnings

The goal of this study fits with the philosophy, strategies and intent of the interpretive paradigm used in this research. This paradigm has the potential to generate new understandings of complex phenomena (Ajjawi & Higgs, 2007), as it seeks “to understand what it is to be human and what meanings people attach to the events of their lives” (Grant & Giddings, 2002, p. 16). An interpretive research approach in this study delves into the meanings of experience as a way of understanding and transforming interprofessional practice and ultimately interprofessional education. Smythe (2002) suggested that we continue to make assumptions about particular phenomena, in this case interprofessional practice, that may in fact not be how they are at all. “From a phenomenological point of view, to do research is always to question the way we experience the world, to want to know the world in which we live as human beings” (van Manen, 1990, p. 5). The interpretive approach of phenomenology seeks to uncover the meaning that comes with the experience of the ‘things themselves’ (Crotty, 1998). A phenomenological view of interprofessional practice, as suggested by van Manen (1990), does not seek to solve its problems, but rather opens questions of meaning; questions of meaning that are shared and enable others to come to their own understanding (Smythe, 2012). This study is also grounded in hermeneutics, which means to ‘interpret’ or to ‘understand’ (Crotty, 1998). Interpretation is historically situated, always requiring the interaction between historically situated text and a historically situated reader of the text (Allen, 1995). Hermeneutics explores what lies behind what is being said through questioning, which seeks the participant’s interpretation of the experience (Grant & Giddings, 2002), and provides a framework from which to value the stories that express others’ everyday experiences (Miles, Chapman, Francis, & Taylor, 2013). “Hermeneutics helps us to realize that there is always much that remains unsaid when someone says something” (Gadamer & Grondin, 2006, p. 91). It allows for a reflexivity to the research process, where the significance of participants’ and researchers’ self-understandings enable some part of the truth to be discovered (Grant & Giddings, 2002).

This study is phenomenological in the sense that it explores the phenomenon of interprofessional practice through stories that recount specific experiences, and hermeneutic in that it endeavours to uncover and understand how participants understand what is meant by interprofessional practice. A hermeneutic phenomenological approach to the interpretation of health professionals’ experience opens up and creates new ways of viewing and understanding the particular phenomenon of interprofessional practice (Koskinen & Lindström, 2013). It allows for the reaching out toward the things of

concern, or the things that summon (Heidegger, 1959/1971). The use of hermeneutic phenomenology has taken me on a reflective journey of discovery – a journey from which the discoveries made remain incomplete, and many more remain undiscovered (McManus Holroyd, 2007). Hermeneutic phenomenological research recognises that coming to dwell on and understand the world is deeply informed by everyday experiences, experiences often taken for granted, that remain hidden or are silenced by dominant perspectives or discourses (Smythe, 2012). Hermeneutic phenomenology represents a philosophical approach that recognises the need to dwell, bring to awareness and interpret experiences of practice that enable the thoughtful and tactful development of interprofessional learning. It underpins and directs the research process by asking ‘how can interprofessional learning be developed to ensure its relevance and ‘fit’ with health care practice?’ This approach resonates with, allows for and accommodates the complex phenomenon of interprofessional practice, and draws on some key notions from Heidegger and Gadamer. Interrelated notions such as Dasein, solicitude, prejudice, genuine dialogue, and the hermeneutic circle are described to aid understanding.

The Philosophers

Heidegger

Phenomenology was a philosophical movement brought to attention by Edmund Husserl [1859-1838] as a radically different way of understanding the world and of doing philosophy at the time (Kafle, 2013). It was a philosophical approach that engaged phenomenological reflection and a focus on the ‘things themselves’ (Sharkey, 2001), in which the grasping of a phenomena was an intentional human process (Lavery, 2003). It was through phenomenology, and the revisiting of the experience of the things themselves, that the possibility of new or enhanced meanings was seen to emerge (Crotty, 1998). In Husserl’s more objective phenomenology, he advocated for what was called ‘bracketing’, the suspension of biases, beliefs and judgements about the phenomenon in order to maintain a level of objectivity in the search for its essence (Allen, 1995; Dowling, 2004; Koch, 1996; Lavery, 2003). Heidegger was one of Husserl’s students, a colleague and successor, and as one of the founders of modern hermeneutics, argued against the suspension of background understandings. Heidegger contended that it is not possible to suspend presuppositions, as preunderstandings are already an embedded part of being human and are not always within a person’s awareness or grasp (Heidegger, 1927/1962; Lavery, 2003). The coming to understand, and the revealing of what it might

mean to be, comes from the world where humans exist (M. King, 2001); a world where there is questioning and enquiry, where there is an already there understanding, one not free from presuppositions (Mulhall, 2005).

Heidegger proposed a shift in focus toward experience and the meanings inherent within the everyday experience of being human (A. Flood, 2010; Heidegger, 1927/1962; Lavery, 2003). This was a shift from Husserl's phenomenology toward hermeneutic phenomenology, from an epistemological to an ontological way of understanding through being-in-the-world (Annells, 1996). "The task of ontology is to explain Being itself and to make the Being of entities stand out in full relief" (Heidegger, 1927/1962, p. 49). An implicit understanding of 'being' and what it means to 'be' was the core of Heidegger's inquiry (Heidegger, 1927/1962; M. King, 2001; Mulhall, 2005).

Heidegger's hermeneutics starts with a phenomenological return to our being, which presents itself to us initially in a nebulous and undeveloped fashion, and then seeks to unfold that pre-understanding, make explicit what is implicit, and grasp the meaning of Being itself. (Crotty, 1998, p. 97)

This thesis looks to explore and question the experience of interprofessional practice and what it means to 'be' an interprofessional practitioner. Interprofessional practice by its very nature is a relational way of being; it is a way of being-with-others-in-the-world. In my attempts to explore this phenomenon, the question of the 'being' of human beings in the living out of interprofessional practice is my concern.

Controversially Heidegger had involvement with the Nazi party, the intent and extent of which continues to be debated (Hope, 2015; Karademir, 2013; Wolin, 1990). Hindess (1992), in reviewing the commentary surrounding this debate, recognised the "weakness of attempts to trace a direct connection between Heidegger's philosophy and his involvement with National Socialism" (p. 120). If indeed his involvement was more than he had alluded and that others have been able to pinpoint, it is incomprehensible that a person of his intellect and standing would allow himself to align to such a monstrous regime; "yet the fact that Heidegger had misinterpreted the signs of history and that he had not thought of a strategy to discern lures does not belittle the relevance of his work" (Hope, 2015, p. 580). Whatever his involvement with the Nazi party and his personal beliefs, while this is acknowledged and not taken lightly, it is his philosophical thinking, writing and contribution to understanding of the world and 'being', that I have focussed on for the purposes of this thesis.

Gadamer

Gadamer was a student of Heidegger who developed and reintroduced hermeneutics into philosophical discussion and extended his ontological exploration of understanding (Grondin, 1994; Koch, 1996). Gadamer was drawn to Heidegger because of his ability to get close to grasping things and because he admired Heidegger's imaginative and powerful thinking (Gadamer & Grondin, 2006). He, as did Heidegger, moved away from Husserl's more objective phenomenology which advocated 'bracketing' in order to maintain a level of objectivity. Instead, Gadamer asserted that interpretation and the coming to understand, which are both inextricably linked, are not possible without preunderstandings, which are present in all understanding and part of the linguistic experience that makes understanding possible (Annells, 1996; Gadamer, 1975/2013). He argued that hermeneutics involves the illumination of the circumstances within which understanding takes place (Dowling, 2004). "Understanding is the culmination of a journey of interpretation that is co-determined by the hermeneutic situations of all involved" (Gadamer, 1975/2013, p. 23), and is always on its way (Annells, 1996). Gadamer asserted that people are embedded in language and culture, where "language is not a tool, it is a way of being" (Allen, 1995, p. 176), with understanding coming from language and through the process of interpretation: "Language is the universal medium in which understanding occurs" (Gadamer, 1975/2013, p. 407) and is considered integral to hermeneutic understanding by both Heidegger and Gadamer. Language is what makes understanding possible in the being-in and existing-in-the-world (McManus Holroyd, 2007). Gadamer contended that understanding is interpretation and is guided by a fusion of horizons between texts and interpreter (Allen, 1995).

The Philosophers' Notions

Six of the key hermeneutic phenomenological constructs as developed and described by Heidegger and Gadamer that particularly helped me formulate my thinking are now explored in relation to interprofessional learning and practice and this thesis.

Dasein

Understanding more about how interprofessional practice is experienced and what it means to those living out this way of being and doing, draws me to consider and reflect on what it means to 'Be' in the being and doing with others in interprofessional encounters. This would not be possible without exploring Heidegger's notion of Dasein, a German word not readily translated to English. As a starting point to understanding

‘being’, Heidegger based his inquiry on the notion of Dasein; this philosophy focussed on Dasein or a way of being-in-the-world (Mulhall, 2005). For Heidegger a human being is Dasein, where Dasein can be thought of as a way of being human as opposed to a specific person or subject (Dreyfus, 1991). “When we designate this entity with the term ‘Dasein’, we are expressing not its ‘what’ (as if it were a table, house, or tree) but its being” (Heidegger, 1927/1962, p. 42).

In its being, Dasein experiences the world through what is called ‘existentials’ that belong to the lived worlds of all Dasein and form an “intricate unity which we call the lifeworld – our lived world” (van Manen, 1990, p. 105). Practitioners’ everyday experience of working with others is experienced through existentials such as of *lived relation* (relationality), *lived body* (corporeality), *lived space* (spatiality), and *lived time* (temporality) and it is these things which have aided reflection and writing (van Manen, 1990). *Lived space* is a felt space and can affect the way a person feels, such as feeling vulnerable, claustrophobic, overwhelmed, insecure or excited. The structure of interprofessional practice calls for a certain space experience, a lived space that presumably impacts on practitioners’ ability to be who they are and be able to practice interprofessionally (van Manen, 1990). This study looks to question and explore the sort of lived space conducive for interprofessional practice. It is in the *lived body* that practitioners present themselves in the world, through their bodies. It is this physical bodily presence or being-in-the-world which is how the person is perceived by others and both reveals and conceals something of themselves (van Manen, 1990). The way in which practitioners manage themselves and their bodies in interprofessional encounters can create an awkwardness or sense of ease in others. *Lived time* is the subjective experience of time and shows itself when it speeds up in enjoyment and slows down in boredom. Lived time is a way of being-in-the-world that shows itself in the practitioners’ temporal horizon of past, present and future, which always remains with them in their understandings of the world, their memories and in the language they use. Who practitioners have become and their horizons of understanding in relation to their past will impact on the way they interpret and understand the present and shape their future interprofessional experiences. It is the *lived relation* with others that provides meaningfulness and purpose (van Manen, 1990), where the qualities and significance of relationships within interprofessional practice might reveal something of its essence. Through the exploration of the relational aspects of interprofessional relationships, insights might reveal something of the meaning of relations in this context.

The existentials are described as “helpful universal ‘themes’ to explore meaning aspects of our lifeworld and of the particular phenomena that we may be studying” (van Manen, 2014, p. 303). They show the complex nature of being-in-the-world. In this thesis I have moved beyond the discrete categories of the lifeworld as described by van Manen (2014); although in my early thinking they were useful as a way into my thinking. The more I read Heidegger the more I came to understand Dasein as encompassing whatever dimension of the lifeworld mattered in the moment of an experience. It could be that a participant’s thoughts were all about ‘other’ and thus the sense of time flying by, the clutter of the room, and the weariness of body receded as he or she told a story of what the other person had said, how that person had inspired him or her, and led him/her into a new way of practice. It was not that the other categories were not part of the experience; rather they tended not to be the explicit focus.

Being-in-the-world is a fundamental constituent of Dasein and Dasein’s being is always Being-with (Mulhall, 2005). “Being as Being-with simply underlines the fact that human beings, no less than objects, are part of the same web, after all their Being is Being-in-the-world” (Mulhall, 2005, p. 72). In looking to explore or to come closer to an understanding of what it means to ‘be’ an interprofessional practitioner, and the practitioners’ lived body, space, time and relations, it is necessary to consider Dasein’s distinctive mode of existence as one of care (*Sorge*). For Heidegger, the world of Dasein is a with-world and is always shared with others, where “Being-in-the-world is essentially care” (Heidegger, 1927/1962, p. 193) Care characterises being, and Daseins’ being shows itself as one of care (Sarvimäki, 2006). Heidegger viewed humans as primarily concerned beings (Annells, 1996), where Dasein not only cares, but its Being is care; care embodies Dasein as a whole (Heidegger, 1927/1962; M. King, 2001; Sarvimäki, 2006). Care as being in the world, means that things are encountered, those things that are ready-to-hand such as equipment, things that are present-at-hand, such as things in nature and the environment, and things to do with the being-with-others-in-the-world (Sarvimäki, 2006). Care manifests itself as concern (*Besorgen*) when it concerns itself with those things that are ready and present at hand, and shows itself as solicitude (*Fürsorge*), in the being-with and relating with others (Heidegger, 1927/1962). Care is central to Dasein’s existence (Gordon, 2001).

Solicitude (*Fürsorge*)

Solicitude is at the core of Dasein’s being. Its focus is on other beings and is a manifestation of ‘care’. Sharing the world with others, being-with others in the working

and learning from, with and about one another, is central to interprofessional practice. How solicitude manifests itself in the ‘being’ and doing of interprofessional practice is a key interest of this study.

In the being-in-the-world, solicitude is a continual process of involvement with others, a process where Dasein constantly repositions itself when engaging with others (Kenkmann, 2005). It occurs within the thrownness of the social world. Daseins’ find themselves in a world where there are already relationships with others, understandings and an attunement with them (Kenkmann, 2005). Heidegger described Dasein as a solicitous entity, coming before indifference or self-interest (Giles, 2008; Heidegger, 1927/1962); however, there are also deficient modes of solicitude that can occur when we “disengage from solicitude for the sake of pursuing self-interest” (Paley, 2000, p. 67), which may show itself as inconsiderateness, indifference, neglect, avoidance, or as self-focussed (Giles, 2008; Sarvimäki, 2006).

Solicitude is described metaphorically by Heidegger as a ‘leaping’, which by its very nature suggests a quickness or unpredictability (Kenkmann, 2005). Solicitude manifests itself in two ways, that of ‘leaping-in’ and of ‘leaping-ahead’ (Heidegger, 1927/1962), where leaping-in is the taking care away or taking over the care, and leaping-ahead which involves going ahead, not to take care away but to allow the other to be free to see the possibilities and act on his/her own terms (Tomkins & Simpson, 2015). Acting solicitously occurs on a continuum, and at the extreme ends may show itself in the case of leaping-in as either destructive for the other, or acting to save the situation. In the case of leaping-ahead, it can be liberating for the other or can leave the other vulnerable and open to failure. How care is manifested on this continuum and the manner in which solicitude is lived, is the choice of each Dasein (Gordon, 2001).

Prejudice

Gadamer (1975/2013) defined prejudice as “a judgement that is given before all the elements that determine a situation have been finally examined” (p. 240), and sees it as a precondition for understanding. It is something learned through experience (Spence, 2016). He viewed prejudice not as the opposite of sound judgement, but that all understanding involves some prior judgement that occurs within an historical and cultural context (van Manen, 2014). Prejudices are always present, lurking hidden. They act as a starting point and are ready to colour how the world is interpreted and understood. Árnason (2000) identified that these presuppositions that are brought into particular

situations can be divided into: cultural presuppositions, things shared by those from the same cultural heritage; personal presuppositions, things that shape individual history and life experiences; and lastly, theoretical presuppositions which are “fostered by the scientific community to which one belongs and shared by colleagues of a discipline” (p. 18). It is these presuppositions that make up the horizon within which experiences are understood. Interprofessional practice involves the coming together of people with different cultural, personal as well as scientific or discipline backgrounds, with their own presuppositions/prejudices in the care of patients. In encounters with others, being mindful of the influence of tradition and the contexts from which understanding of the world comes, enables understanding to take place. Gadamer (1975/2013) stated: “The task of historical understanding also involves acquiring an appropriate historical horizon, so that what we are trying to understand can be seen in its true dimensions” (p. 313).

Understanding the world starts with self-understanding, which involves an awareness that current understandings are influenced by prejudices (Debesay, Nåden, & Slettebo, 2008). An awareness of the prejudices governing understandings is called ‘historical consciousness’, which enables an awareness of the effect of historical influences on interpretation (Smythe, 2002). Historical consciousness, described by Allen (1995), occurs when there is an analysis of the contexts or conditions under which the text was generated and the meanings related to the particular context. Seidman (1998) suggested that without an understanding of the context there is little possibility of being able to explore the meaning of an experience. “What interpretive hermeneutic understanding offers the inquirer is the ability to begin to see the way in which our blind attachment to certain classifications and categorizations limit how we understand and come to know our world” (McManus Holroyd, 2007, p. 3). The interpretation resulting from effective historical consciousness is the fusion of the text and the context in which this sits, with the researcher and his or her particular context (Allen, 1995). A fundamental hermeneutic imperative is the need to identify, challenge and qualify these prejudices. Negotiation of meaning in hermeneutic analysis is always within a context of preunderstandings and prejudice.

As the researcher in this study, I am aware that there is no one correct interpretation of text, and how I come to understand the world is rooted in my historical, cultural and social context. Being aware of the preunderstandings and prejudices that I bring and that have been voiced in Chapter one, as well as an awareness of what the participants bring that shape and influence their understandings and perspectives, will enable exploration

of the meanings they attach to the interprofessional experiences they describe. Geanellos (1998) stated that one has to engage with the text within the hermeneutic circle, address preunderstandings, reflect on them, and consider their influence and the context within which the study sits.

The hermeneutic circle

Interpretation enables the establishment of meaning of a text (Debesay et al., 2008). Interpretation and understanding occur as a circular, continuous and ceaseless process that involves recognition and a gathering up of prejudices formed within historical cultural, personal and scientific contexts (Lawn, 2006; Lawn & Keane, 2011). It is unknown when the notion of the hermeneutic circle was first described (Geanellos, 1998), although the notion is believed to have originated from Schleiermacher [1768-1835] and is commonly understood as a movement between the parts and the whole depicting a circular process of interpretation and understanding (Annells, 1996; Lawn & Keane, 2011). The art of understanding within the hermeneutic circle comes from having an understanding of the whole in relation to the detail and the detail in relation to the whole (Gadamer, 1975/2013). Having an understanding of the whole presupposes that there must be some understanding of its parts that contribute to the whole.

Participation in the hermeneutic circle and the coming to interpretive understanding is described by Koch (1996) as the combination of prejudice and tradition, and is an open and ongoing dialogue that has no final conclusion (Geanellos, 1998), where tradition is the “horizon within which we conduct our thinking” (Nyström & Dahlberg, 2001, p. 341). It is a dialectical and continuing experience for those involved (Koch, 1996; Roberge, 2011), where the acquiring of new knowledge/understandings means that there is constant movement within the hermeneutic circle (Debesay et al., 2008). Gadamer (1975/2013) stated that “we always find ourselves within a situation, and throwing light on it is a task that is never entirely finished” (p. 312). Prejudice determines the nature of perspectives and judgements about the world and tradition is the history of events in which the present is rooted: interpretation comes with prejudices based on traditions (Koch, 1996).

Throwing light on what it means to be an interprofessional practitioner and the beingness of interprofessional practice is a work in progress, it will never have a conclusion. It requires a willingness to let go of what is currently known and a reciprocal conversation with the texts/stories to consider how these work to shape what it means to be an

interprofessional practitioner. However, there will always be a different interpretation – interpretations based on prejudice and tradition and the fusing of the old and new horizons of the interpreter.

Fusion of horizon

Gadamer (1975/2013) described a horizon as “the range of vision that includes everything that can be seen from a particular vantage point” (p. 313). It is a perspective on the world that is partly acquired through language, and enables “one to ‘see’ and to ‘see differently’” (Lawn & Keane, 2011, p. 51). Hermeneutic inquiry aims for a fusion of horizons of the interpreter and the stories/text. Understanding occurs when there is fusion of the horizons between the interpreter and interpreted, as well as horizons of past and present (Crotty, 1998; Debesay et al., 2008). The horizons of the present cannot be formed in isolation from the past, a past which is always in motion (Gadamer, 1975/2013).

Gadamer (1975/2013) suggested that when attempting to understand horizons “we do not try to transpose ourselves into the authors mind but, ... we try to transpose ourselves into the perspective within which he has formed his views” (p. 303). In order to gain a clearer view of the whole and to provide a perspective/horizon of what it might mean to ‘be’ an interprofessional practitioner, I am mindful of my own horizons, the horizons of the other/text and open to challenging these existing horizons of understanding, to enable a ‘seeing’ beyond that which is near. Openness is considered by Gadamer to be the answer to dealing with preunderstandings that result in prejudice; an open attitude to new situations enables the otherness of the phenomenon to show itself (Nyström & Dahlberg, 2001).

Genuine dialogue

Gadamer (1975/2013) asserted that “Language is the medium in which substantive understanding and agreement takes place between two people” (p. 402), through the process of dialogue. Genuine dialogue for Gadamer is when two people try to come to an understanding, a conversation where there is an openness to truly accept the other’s point of view and to understand what the other is saying (Gadamer, 1975/2013). “Only in conversation, only in confrontation with another’s thought that could also come to dwell within us, can we hope to go beyond the limits of our present horizon” (Grondin, 1994, p. 125). Gadamer claimed that truth is to be found by entering into genuine dialogue and Grondin (1994) asserted that there is no principle higher in philosophical

hermeneutics than dialogue. Dialogue reveals something about its participants. Those involved in the dialogue are changed during these encounters, they are forced to see things differently as prejudices are revealed and initial assumptions are challenged and modified (Lawn & Keane, 2011).

Gadamer criticised claims of objective knowledge, which he believed do not allow dialogical understanding and consequently a lack of a fusion of horizons (Árnason, 2000; Gadamer, 1975/2013). Árnason (2000) suggested that frustration experienced by healthcare patients may be the result of methodologically focussed healthcare practitioners, who prioritise objective knowledge, which works to shut down openness and genuine dialogue. When dialogue is not prioritised and there is a lack of understanding of one another, it is easy to give up or abandon the dialogue (Vilhauer, 2013). Unless there is engagement in dialogue and open conversations about the meaning of the phenomenon, an understanding of its transformative potential will not be uncovered (Smythe et al., 2007).

Central to the process of genuine understanding and what ought to happen during the hermeneutic process is a responsiveness, creativity and freedom that comes with engaging in conversation/dialogue (Gadamer, 1975/2013). It is in dialogue with the stories that I have been able to see things differently. Recognising the uniqueness of my own and others' horizons, and remaining open to what has shaped these perspectives, enables a movement between tradition and interpretation; an openness to the possibilities; toward understanding.

Why Hermeneutic Phenomenology?

The complexities inherent within, and the variable understandings of interprofessional practice and learning were highlighted in the earlier literature review. Hermeneutic phenomenology provides the foundation from which to explore the complex thing that is interprofessional practice and what it means for those who live the experience. "Both Heidegger and Gadamer, through their distinct philosophical developments, offer the researcher the philosophical underpinnings for more fully understanding the contextual, complex life of individuals" (McManus Holroyd, 2007, p. 10). This thesis aims to open up the phenomenon of interprofessional practice, to disclose something of itself that has been unseen, though hearing health practitioner experiences of working with people from different disciplines. It is through the stories that insights will be gained which can then work to shape and inform interprofessional learning. Hermeneutic phenomenology shows congruence with this research study in a number of ways: through its emphasis on

understanding through experience which is a continuous movement between parts and whole; through the dialectical too-ing and fro-ing in dialogue which generates new and differing understandings, broadens horizons and moves toward a fusion of horizons; through the unveiling or revealing nature of questioning related to the experience of the phenomenon itself; through the recognition that understanding is not possible or separate from background understandings or prejudice; and through its emphasis on the universality of language which is of critical importance at all levels of interprofessional practice, between healthcare professionals and patients and in the research process (Annells, 1996).

In the initial stages of thinking about this study, I considered taking a critical approach because of the unmistakeable cross-disciplinary issues inherent in the coming together of health professionals in interprofessional practice, such as power relations and hierarchy. However, on reflection I considered gaining an understanding of the phenomena itself an important first step. The aim of the study arose out of a desire to shape and deliver interprofessional learning relevant for current and future health professionals. This lent itself to an approach which focussed on the experience and personal insights from practitioners, in order to come closer to understanding the thing that is interprofessional practice, which might go some way to enriching the development of interprofessional learning. Hermeneutic phenomenology is the beginning place, and I would be 'jumping the gun' if I were to start with a critical inquiry without first having a clearer understanding of what the phenomenon of interprofessional practice 'is'. Moving onto a critical study of the power differentials at play within interprofessional practice seems a logical follow up to a phenomenological exploration of the thing itself.

Grounded theory, which aims to explore and explain basic social or psychological processes of a particular experience (Grant & Giddings, 2002), was also considered as a possible methodology for this study and was also discounted. It was felt that the complexity and interrelatedness of interprofessional practice reduced to a single theory or theoretical model may not show the subtle nuances in the evocative manner of someone recounting what happened. I wanted to stay as close as possible to the stories of experience and the messy and complex nature of interprofessional practice, whereas grounded theory focuses on the development of a substantive theory (H. S. Wilson & Hutchinson, 1991).

Summary

Some of the guiding philosophical notions from Heidegger and Gadamer that have underpinned this study have been introduced; notions that have challenged me to look beyond what appears on the surface and to move forward in the research endeavour with a phenomenological attitude.

The philosophical orientation and underpinnings of hermeneutic phenomenology have allowed me to reshape my understandings and to more fully understand the human phenomenon of interprofessional practice. It has allowed me to recognise the limits of my own horizons and, through dialogical engagement, be open to difference within the stories. This has enabled me to breathe new life and gain new insights into what it means to be an interprofessional practitioner and the conditions that may act to sustain this way of being. The use of hermeneutic phenomenology has allowed me to stay close and attuned to the ontological nature of the phenomenon and has provided a lens through which I have progressed in this journey of understanding. I have come to understand that my quest is not to find the answers, but to uncover the hidden, to question, to remain open to the possibilities, and to move closer to the essential meanings that have emerged.

The notions within this study, guided by Heideggerian and Gadamerian hermeneutic phenomenology, are consistent with my own ontological view of being in the world and my situated engagement in all phases of the research process. The following chapter goes on to discuss these phases within the research process and how the philosophical underpinnings outlined here have guided the ways in which I have carried out this study.

CHAPTER FOUR

RESEARCH METHOD

Thinking is the interpretive act which brings understanding, which is thinking, which is interpretation – there is no linear progression to an end point, rather a lived experience of dwelling with the possibilities of what something could mean. Hermeneutic thinking is not something done in one’s ‘mind’ in a logical, systematic manner. Heidegger suggests thinking already has a mood; we are already perplexed, or anxious, or dismissive. We are already drawn to a particular part of the story; already sensing what matters; already overlooking the taken for granted.
(Smythe, 2011, p. 44)

Introduction

Having chosen to use a hermeneutic phenomenological approach to guide and shape this study, an approach that reveals the meaning within experience, that questions, that prompts thinking, that enables the seeing of meaning within the text, I turned my attention to how I might actually go about doing this in terms of a research process. In undertaking the process, I was aware of the need to hold the philosophical foundations “as a beacon to light the journey” (Smythe, 2012, p. 12).

Gadamer was not concerned with developing a research method or methodology; his focus was philosophy (van Manen, 1990). He was concerned that with a concentration on method comes a narrowing of perspective and reflection (Gadamer, 1975/2013). Hermeneutics is about safeguarding the things that matter, but given its ‘emergent nature’ and its lack of a predetermined process for the safeguarding and preserving or bringing the things that matter to awareness, it is not without its challenges (Lincoln & Guba, 1985). The use of method in itself does not lead to good interpretive outcomes; rather method is guided by factors such as the use of scholarship, tact, judgement and taste (Sharkey, 2001). van Manen (2014) suggested that given the lack of a procedural, step-by-step method for conducting research, “the researcher can aim and aspire to cultivate his or her inquiry program and practice by attentively attending to Heidegger’s thinking” (p. 231). Engaging in hermeneutic phenomenological research is described by Smythe, Ironside, Sims, Swenson, and Spence (2008) as a ‘journey of thinking’; a process that van Manen (1990) described as requiring the researcher to find creative methods suited to the particular topic of interest, the context, and the individual researcher.

On this thinking and learning journey into the being-ness of interprofessional practice, health professionals with experience working with health professionals from other

disciplines were asked to describe moments, experiences, stories, perspectives and understandings of working with others. It is through experience that we become familiar with phenomena and able to discuss their essential meanings. The telling of stories which express experiences of a phenomenon reveals its meaning, and the writing down of these stories enables the thorough examination of meaning structures present within the stories (Lindseth & Norberg, 2004). “Essential meaning must be studied and revealed in the interpretation of text” (Lindseth & Norberg, 2004, p. 147). In the process of interpretation of the stories and the uncovering of meaning, I remained open to myself and recognised that I would never be able to understand all there is to understand as time, people and experiences are constantly moving and changing (Smythe, 2002). I was also ever mindful of the sociocultural and historical contexts that opened up and allowed for the broadening of horizons, and the enrichment of my understandings on this topic. This chapter captures the way in which the study has been accomplished, providing details of the steps taken to achieve this aim.

Ethical Considerations and Approval for the Study

Approval for this study was gained from the Auckland University of Technology Ethics Committee (AUTEC) (Appendix A - AUTEC approval letter). Approval allowed me to recruit 12 New Zealand based health professionals as participants in this study. The participants were recruited through an intermediary and word of mouth through professional networks - the snowball method (Tracy, 2012)

One of the expectations of research conducted in Aotearoa New Zealand is respectful consideration of Māori, aligning with 3 key principles derived from the Treaty of Waitangi: Partnership, Participation, Protection. Careful consideration was given to key ethical matters in this study to ensure the safety and protection of the participants, with the principle of partnership enacted through consultation and action in honesty and good faith. Participation was voluntary and the privacy and anonymity of participants was respected and maintained, with no identifying features related to themselves, the organisations they referred to or the events they described, included in the study.

In the event of Māori participating in this study, consultation with my supervisors, Māori academic staff at AUT, and other colleagues was planned to ensure that care was taken in the research process to identify and reduce any risk in relation to Māori. Consultation was sought from Māori academics within AUT and external to AUT via a Māori health practitioner and researcher, specifically in relation to the recruitment process and to assist with the interpretation of Māori participant stories. One of my intermediaries was

specifically approached to identify potential Māori participants from her professional contacts. However, no Māori health professionals approached me to participate in this study. I chose not to pursue Māori recruitment past these initial efforts as there was unlikely to be any direct benefit for Māori as a result of this study. By treating all participants with respect and ensuring the confidentiality of participant information, I have sought to act in good faith towards participants and to honour the principles of Partnership, Participation and Protection outlined in the Treaty of Waitangi.

This study encouraged autonomy of participants through the use of recruitment strategies that were designed to gain informed consent and minimise the possibility of coercion. In order to ensure any decision to participate was an informed one, prospective participants were provided with information on the research, its purpose, and what was expected, and were offered the opportunity to consult with the researcher to assist them to consider whether they wanted to pursue research participation further.

Mutual respect and autonomy were also enabled by ensuring the interviews were convenient for the participant in terms of location, timing and duration, and in the way in which the interviews and research process proceeded. The nature of hermeneutic phenomenology encourages open dialogue, a listening attitude and a focus on the participants and their experiences. It allows the participants time to consider their experiences and what those experiences mean to them without the pressure of too many structured questions. The participants' stories and experiences of working with other health professionals formed the basis of this study, therefore their contribution and participation was greatly appreciated and has been acknowledged in this document.

The Study Participants and Recruitment Process

Given that the study concerns interprofessional practice, a mix of professions were sought to inform the analysis. Purposeful sampling was used in the selection of participants who would be able to illuminate the phenomenon of interprofessional practice and who could draw on stories rich in detail and understanding (Smythe & Spence, 1999). Purposeful sampling selects research participants who match the criteria determined by the research purpose (Tuckett, 2004), in this case health professionals who have experience working with practitioners from other disciplines in the delivery of care. In addition, representation from a range of ethnic groups, recently graduated as well as more experienced practitioners, working in both education and practice environments, was considered and prioritised in the selection process. The aim was to allow a range of perspectives to emerge in relation to the realities of current practice, and the

understandings and influences of the participant. The inclusion criteria were that participants had practice experience that involved working with other health professionals in the delivery of patient care within the last 5 years, and a minimum of 1 year of practice within a New Zealand healthcare context. The participants needed to be available to be interviewed within the greater Auckland region, however provision was made to extend this as far north as Whangarei and as far south as Hamilton if necessary. All participants were required to have conversational English. Those excluded from the study included anyone with whom I had a direct supervisory relationship. This was necessary to reduce the likelihood of influences of a coercive nature between the researcher and the participant due to the possible power differentials that may exist in a supervisory relationship.

Recruiting and selecting participants

Most health professionals today have some experience of working with health professionals from different disciplines. This, along with the fact that the inclusion criteria for the study were relatively broad, meant that there were few barriers to the recruitment of participants.

One of the ways in which recruitment occurred was through an intermediary. The identification of intermediaries who had links to practice enabled me to find participants who were working in practice and met the selection criteria, and acted to ensure there was no unintended coercion from myself as the researcher in the study.

The intermediaries were selected because they were known to me and were in positions that enabled them to have developed a wide range of contacts both in practice and/or education environments. Potential intermediaries were sent an email which outlined the proposed research and requested their assistance in the recruitment of possible participants (Appendix F – Sample email to intermediaries). Once the intermediaries had accepted this role, either verbally or via email, a follow-up email was sent to them outlining in more detail the specific requirements of this role. It entailed identifying and emailing information to between 1 and 4 possible participants who met the inclusion criteria. The first email sent to prospective participants provided them with the flyer which introduced them to the research and contained my contact details if they were interested in finding out more (Appendix B – Flyer). Intermediaries were also asked to email out two pre-prepared, blanket reminder emails at different intervals. To retain confidentiality of those who volunteered to participate in the study, reminders were sent

in accordance with the schedule, whether or not the recipient had responded. When potential participants expressed an interest in participating in the study, more detailed information by way of participant information was provided before any agreement to participate was sought (Appendix C - Participant information sheet).

Not all participants were recruited through an intermediary. Participants were also able to approach me directly if they had heard about the study from within their professional networks and were interested in participating. They were then provided with the flyer and asked to follow the process outlined to confirm their interest in participating. Five participants were professional contacts who had heard about the study and expressed an interest in being involved, two of whom were also acting as intermediaries in the study. The rest of the participants were recruited after receiving information through an intermediary.

As the interviews progressed, I began to realise that in order to capture greater depth and richness in the data it would be beneficial to select participants who had specific experience of working in highly collaborative or interprofessional teams. This slowed down the data collection phase a little, as the intermediaries were asked to identify health professionals whom they knew were working in this way or, if they did not, to recommend others to act as intermediaries. However, the process of recruiting participants generally worked well, with sufficient and appropriate participants seeming to come to me at the right times. Because data collection occurred over a period of eight months, I did not require all of the participants at the start of the research. This involved a rolling recruitment, where intermediaries approached potential participants at different points in the study as required.

The study participants

Twelve participants were recruited and interviewed for this study and came from a range of health disciplines; 2 from nursing, 3 from physiotherapy, 2 from occupational therapy, 1 midwife, 1 speech and language therapist, 2 social workers and 1 doctor. These 6 different disciplines worked in a variety of practice and education environments including paediatrics, child protection, palliative care, accident and emergency, neurology, surgery, residential care, child and adolescent mental health, alcohol and other drug services, forensic and early psychosis as well as those now involved in clinical teaching within tertiary health education settings.

All of the participants worked in the greater Auckland area, but drew on their experiences of working with others throughout their careers, some of which included stories of international practice. Nine of the 12 participants were female. Two had less than 5 years practice experience, 2 had over 20 years experience and the rest between 11-20 years. Five participants were under 40 years of age and a range of ethnic backgrounds were represented, including 4 participants who identified as British, Filipino, Samoan/New Zealand European and Canadian, the others identified as New Zealand European/Pakeha². See Table 2 (p. 82) for a summary of participant demographics which was gathered and listed in order of recruitment.

Consent and confidentiality

When prospective participants contacted me, I provided further information if requested, either verbally over the phone or in person or written via email. Upon agreeing to participate in the study, participants were asked to complete a consent form prior to the interview (Appendix D – Consent form).

Confidentiality of the participants and other people mentioned during interviews was maintained, with identifying information removed from the stories and names replaced with pseudonyms. Digital recordings and original transcripts were assigned a code and kept on a password protected hard drive during data collection and data analysis, and afterwards held in locked storage in my office. Computer files were password protected and all recordings will be destroyed after a period of 6 years. It was not envisaged that any harm would come from participation in this research. Participants were aware that they could withdraw their data; however it was made clear on the participant information form, that depending on the point at which they wished to withdraw, it may not be possible to extricate their contribution from the analysis. No one withdrew data from the study.

² Pakeha - New Zealander of European descent - probably originally applied to English-speaking Europeans living in Aotearoa/New Zealand (Moorfield, 2017)

Table 2: Participant Demographics

Pseudonym	Profession	Age	Years Experience	Current Role	Previous Clinical Experience
Carey	Physiotherapist	30-39	11-20	Clinical education and acute care	Rehabilitation
Carol	Midwife	40-49	0-5	Independent midwife	N/A
Vivian	Speech & Language Therapist	40-49	11-20	Clinical education, acute and community care	Neurology
Amy	Occupational Therapist	30-39	11-20	Child & adolescent mental health and clinical education	Community and Palliative care
Paula	Nurse	40-49	20+	Education	Paediatrics, respiratory care and child protection
Jenny	Physiotherapist	30-39	11-20	Rehabilitation	Assessment, treatment and rehabilitation services, and acute, community and outpatients
Amanda	Doctor	40-49	11-20	Emergency medicine	General practitioner, general medicine, paediatrics, surgery and psychiatry
Ricardo	Nurse	20-29	0-5	Mental Health	N/A
Thomas	Physiotherapist	30-39	11-20	Education	Hospital, private practice and community
Theresa	Social Worker	50+	11-20	Rehabilitation	Child health, women's health, general medical
Tony	Social Worker	50+	11-20	Child and adolescent mental health	Alcohol and other drugs service, early psychosis
Joselyn	Occupational Therapist	50+	20+	Residential care	Inpatient, community and occupational therapy education

Collecting the Data: The Interview

This study used in-depth, semi structured interviews to gather and explore health professionals' practice stories, perspectives and understandings of interprofessional practice. Before the interviews took place, I thought about and planned what I would ask

in line with phenomenological thinkers and in consultation with my supervisors. I purposefully worked to play down the notion of a formal interview and in an attempt to keep the process more relaxed, introduced it to participants as a conversation.

Consistent with the Gadamerian philosophical approach to this study, I was interested in the person's understanding of interprofessional learning and practice, and how specific experiences have shaped or influenced these understandings. Entering into conversation with the text and asking the right questions was, for Gadamer, the way to truth (Gadamer, 1975/2013; Sharkey, 2001). Gadamer (1975/2013) was also concerned that a too structured approach may stifle the unfolding story, resulting in hidden meanings being missed. Smythe et al. (2008) suggested that to go into an interview with the idea of 'conducting' it would be "to freeze the phenomenological spirit" (p. 1392). Openness and a listening attitude are considered essential ingredients in generating a phenomenological conversation (Smythe, 2011) and "what matters most is openness to what 'is' – to the play of conversation" (Smythe et al., 2008, p. 1392). I used guiding questions in an attempt to focus on the participants' experience, to draw them into the conversation, and encourage them to bring their experiences or words to life, which is described by Smythe (2011) to be the quest of hermeneutic interpretive phenomenology (See Appendix E – Sample of guiding questions). My aim was to create a relaxed environment and a relationship that focused on the experience and the meanings attached to the experiences through open dialogue, where each conversation was "uniquely itself" (Smythe et al., 2008, p. 1392).

The interviews were opened by asking the participants to think of an encounter or experience when they were working with one or more health professional/s from another discipline. While the participants were aware that I was interested in interprofessional education and practice, I did not start off using this terminology and did not ask them to specifically describe an 'interprofessional' interaction. My avoidance of the term interprofessional practice was deliberate because it implies specific knowledge, skills, attitudes and behaviours associated with it, which may have limited participants' ability to reflect on and contribute valuable cross-disciplinary experiences. I was interested in their everyday encounters of working with other health disciplines and discovering fresh insights from these interactions, which may help to inform understandings of interprofessional practice and shape interprofessional education into the future. I was ever mindful of how I was, the prompts I offered in the conversation, and the powerful nature of questioning where "a person skilled in the 'art' of questioning is a person who

can prevent questions from being suppressed by the dominant opinion” (Gadamer, 1975/2013, p. 376). The conversational style and the guiding questions and prompts I used assisted me in my attempts to capture stories as close to how they happened as possible. I was mindful of van Manen’s (2014) warnings surrounding the difficulties for the interviewer in eliciting pre-reflective experiential accounts of experience, because interviewees will often resort to telling about, and reflecting on, the experience as lived. Despite the guiding questions, the interviews were conversations that took a life of their own, with twists and turns, and that reached their own conclusions (Gadamer, 1975/2013). Hearing and gathering stories and perspectives provided the opportunity to gain a richer understanding of the phenomenon itself (van Manen, 2014).

The intention was to undertake one interview with each participant, however a second interview was not ruled out as it might have enabled aspects of a participant’s story to be clarified, or the gathering of more specific details related to the origins of their understandings (Smythe & Spence, 1999). No second interviews were considered necessary.

All of the interviews took place in locations identified as suitable by the participants and included meeting rooms within the university, at the participant’s workplace, and within the participant’s home. Each interview lasted between 45 and 65 minutes and I was mindful of the need to keep the interview focussed to ensure the time was used wisely. Each interview was audio recorded, transcribed verbatim and dwelt upon before moving onto the next interview, where possible.

In the first 5 to 6 interviews my questions were fairly general, focussed on gathering as many stories as possible and unpacking these stories. The focus at this stage was breadth. For example, I asked participants to “describe a time, event or situation when you were working closely with one or more people from another profession” or “I’d like to hear your story about that encounter, what led up to it and what transpired”. As the interviews progressed, common threads began to emerge and a need to pursue these lines of thinking became more evident. Questions became more focused on gaining greater depth in the areas I had identified as important to interprofessional practice. For example, “I’m interested in this whole idea of people being afraid to look silly. What is that about? Why are people afraid to speak out?” or “I’m interested in hearing about your approach to establishing relationships.”

Feedback from some participants indicated that the process of recollecting their practice experiences and reflecting on them was a useful exercise. It highlighted for some how

far they had come, and for others how much work still remained to develop better practices and relationships with others in their work places.

Researcher considerations

During the interviews, it was difficult to keep participants focussed on the actual experiences as they had experienced them at the time, on how the encounters had transpired, what had occurred in the moment, who said what, how they felt, and what made the encounter possible. Some of the participants were able to take themselves back as close to the encounter as they could remember, but many found this challenging. They instead gave more generalised, brief and broad descriptions of the experience, choosing to focus on their own interpretations of the experience. Prompt questions were used in an attempt to get them to consider what was happening at the time and to delve deeper into the experience itself. As the interviews progressed, I began to see that despite these often broad descriptions and reflections, I was still able to capture rich data. The experience itself was the basis for further exploration of the situation presented, allowing a deeper understanding of the phenomenon and the historical and sociocultural context within which their understandings were formed. I began to see the ‘hermeneutic’ aspect of the research process in play and how phenomenology, with its grounding in rich stories of experience, came together with hermeneutics in exploring what participants thought about the experience as lived. Remaining strongly oriented on the research question, to ensure the interview remained focused on the phenomenon of interest, was an important part of this process (van Manen, 1990).

As a health professional and an educator of interprofessional practice within a tertiary education setting, I brought my own prejudices, values, perspectives and mood to the interview, an inevitable precondition of understanding (Gadamer, 1975/2013). “There is undoubtedly no understanding that is free of all prejudices ...” (Gadamer, 1975/2013, p. 506). Acknowledging that understanding occurred from my own particular historical and cultural context, shaped the questioning and interpretation process. “Heidegger suggests thinking already has a mood...We are already drawn to a particular part of the story; already sensing what matters; already over-looking the taken for granted” (Smythe, 2011, p. 44).

In my eagerness to follow a number of lines of thinking raised by the participants’ stories and understandings, I would often find myself wanting to listen to their current train of thought, but also wanting to pick up on other ‘bits’ they had offered and not lose the

opportunity to explore these lines of thinking. I often heard myself say, “Oh that’s interesting, let’s come back to that!” Sometimes, despite my best intention to return to an interesting point, I would lose the moment or forget what I had wanted to return to. “To play along is to go with the thoughts that excite, confuse, perplex” (Smythe et al., 2008, p. 1302). I began to play along, and encouraged a line of thinking that intrigued and excited me, through the use of prompts such as ‘go on’, ‘tell me more’ or a simple nod. I made no attempt to disguise my mood, prejudices or interest in aspects of the participants’ experience.

I was particularly mindful of the need to let the stories of interprofessional experience lead the conversation. This was because of my tendency toward being directive and at times struggling with the thought of uncomfortable silences. Being able to allow participants to tell their stories in their own way with minimal prompting and to see the value in silence remained a challenge for me throughout the interviews. However as the interviews progressed, I became more able to immerse myself in the ebb and flow of the conversations, to let them go and let them be.

Working with the Data

Transcribing and re-crafting into stories

After each interview was completed, it was transcribed verbatim, with all except one transcribed by a professional transcriptionist. I chose to transcribe the first interview. I wanted to get a feel for the data and stay immersed in it throughout the recrafting process, as it is in the reading and recrafting that interpretation begins (Caelli, 2001). I soon discovered that although it allowed me to fully immerse and gain a real sense of the data, transcribing on its own is very time consuming.

The remainder of the transcripts were read alongside the audio recording to ensure accuracy and then read a number of times to ensure I was immersed in the data. This immersion and dwelling with the data allowed stories of particular events described within the transcripts to emerge. Many of the stories announced themselves, standing out either because they resonated with me or were, I sensed, important to the participant.

Once a potential story was identified, I began to recraft it, to hold and showcase the participant’s meaning, making them easy to read and omitting grammatical errors (Smythe, 2011). Deriving stories from the raw interview transcripts was found by Caelli (2001) to be an accepted way of working with the data that better enabled participants to clarify and validate their contributions. I worked to find threads of the particular story

throughout the transcript and to re-organise it into a logical and chronological order, careful to use the participants' own words, editing grammar and punctuation where necessary and removing distracting details to ensure they read well. My intent was to bring their meaning to light, not to change the meaning (Smythe & Spence, 1999). In the recrafting of this 'telling' by participants into stories, I was careful to identify those which I felt conveyed something of the meaning of the phenomenon of interprofessional practice. I was drawn more to some transcripts than others, with some transcripts yielding multiple stories and others very few. I drew on the stories which most clearly gave accounts strongly linked to ways of being interprofessional and those stories which showed how these ways of being were safeguarded and preserved. Stories that were not included are in no way negated or of lesser importance, as they contributed to my understandings and interpretations and the final themes that emerged.

As specified in the participant information sheet (See Appendix C), these crafted stories were returned to the participants to confirm that I had not altered the meaning and they would be happy for the information they provided to be told in this way. There was overall confirmation from participants that the stories reflected the participants meaning and captured the essence of their stories. Two participants requested minor changes to what they perceived to be possibly identifying features. These were made and returned back to the participants for verification.

The reading, the listening and the recrafting brought with it understanding: "We gain understanding together as we take in the situation, recognising the movement of the whole and realising the contribution of the parts" (Koch, 1999, p. 26). Understanding occurs within a hermeneutic circle (Gadamer, 1975/2013), where the questions influenced the emerging stories, which in turn influenced further questioning. The stories used in the study were influenced by my preunderstandings of what mattered or what I came to realise as important in relation to the phenomenon. The reflexive nature of interpretation meant that my own background understandings, prior knowledge and experiences influenced the process of data gathering as well as analysis/interpretation (Sloan & Bowe, 2014).

Interpreting the Data

Interpretation, as suggested by (Koch, 1999), "is what I believe the person or text is getting at" (p. 27). It is a way of drawing meaning from the participants' stories; stories which represent the ways in which they have come to make sense of the world. Interpretation, as Gadamer suggested, is both a pointing toward something and a pointing

out of the meaning of something (van Manen, 1990). Interpretation of the participants' stories was a pointing to, a revealing of those things that were already associated with the phenomenon of interprofessional practice; things which may have been covered over or hidden in the everydayness of practice. It is a pointing out of something that occurs when "we confront something that is already an interpretation" (van Manen, 1990, p. 26). In this study, the pointing out of what it means to be an interprofessional practitioner was often already an interpretation offered by the participants. It was they who chose the stories that in their minds reflected the phenomenon of interprofessional practice. It was they who described the manner and value of such relationships.

Interpretation involved looking for unifying themes across participants' stories, drawing on the philosophy of both Heidegger and Gadamer and the wisdom from dialogue with my supervisors in making sense of the text. The next and final stage of the analysis was the writing up and synthesis of my findings into the chapters. It was in forming these chapters, in the writing and rewriting and the drawing on the philosophical notions, that a deeper understanding of what it means to be an interprofessional practitioner and how this way of working can be safeguarded has emerged. This is an understanding which is never final, always open to interpretation.

Analysing the data occurs through the application of the hermeneutic circle, a cycle of rigorous reading, reflective writing and interpretation, where the writing and rewriting are embedded within the interpretive process (Kafle, 2013; van Manen, 2014). It involved dwelling with the data, reading and re-reading the stories, going back to the data to refine and deepen the analysis and writing and re-writing. The analytic process was guided by six methodological themes described by van Manen (1990) to provide a practical approach to those undertaking hermeneutic phenomenological research. The analytic process of this research involved a dynamic interplay between these six research activities, which were used as a guide in the analysis and interpretation of the participant experiences. The six methodological themes applied in this study are turning to the phenomenon, investigating the experience as it is lived, reflecting on the essential themes, the art of writing and rewriting, maintaining a strong and oriented relation, and balancing the context of the research by considering the parts and the whole (van Manen, 1990).

Turning to the phenomenon

Turning to the nature of lived experience, where lived experience is described as the starting and end point of phenomenological research, is the practice of thoughtfulness, of “thinking a single thought more deeply” (van Manen, 1990, p. 31). I set out to make sense of the experience of interprofessional practice with the purpose of informing interprofessional learning, and I was oriented to it in the context of my particular individual, social and historical life circumstances. Although interprofessional practice could in itself include an infinite number of experiences, my focus was to gain insight into its essential nature, and draw meaning embodied within the experience of interprofessional practice in order “to construct a possible interpretation of the nature of a certain human experience” (van Manen, 1990, p. 41). I had to ask ‘in what sense are the stories examples of interprofessional practice?’ and set out to understand the whole of each story and its parts by paying attention to each sentence and the words used in relation to the text as a whole. It was in questioning, in laying open, in thinking, and a trusting in the process as the research progressed, that deeper layers of meaning came, enabling me to move toward a deeper level of interpretation. To do this, I read and re-read the transcripts to get a sense of the different experiences of the phenomenon relevant to my question. In dwelling with the transcripts and in the thinking about possible stories, I looked for meanings, for themes that emerged in the transcripts and captured some initial thoughts in relation to each theme. I used basic mind mapping to capture what I sensed was important in the text, and in relation to the themes that emerged (See Appendix G - Examples of initial mind map). I looked for the stories that lay within the transcript, stories that related to these possible themes. I was drawn to certain stories and crafted these into individual stories, to make the point stand out clearly, crafting the sentences so that they read well, altering the ‘how’ of what was said, not the ‘what’ (Smythe, 2011) (See Appendix H – Example of raw data to recrafted story). Once stories had been pulled together, I read and re-read them, gaining a sense of the overall essence of the particular story and then considered the sentences and words used that gave the story its meaning.

Investigating experiences as they are lived

Lived experience is the immediate, pre-reflective, and reflexive awareness of life (Dilthey, 1985) that cannot be grasped in the midst of the living experience, only reflectively after the event (van Manen, 1990). Participants have drawn on the pre-reflective aspects of their lives in the immediateness of working with others, and they

became reflectively conscious of these experiences in the act of the interview – in the conscious reflection and looking back on the experience (van Manen, 1990).

In the turning toward the things themselves, I as the researcher am not only immersed in the world that I live, but am actively engaged in the exploration of the nature of the lived experience of interprofessional practice. Investigating experiences as they were lived, and drawing on others' experiences, informed understandings of the particular phenomenon (van Manen, 1990). Going back and dwelling on the actual experience of working or collaborating with a health professional from another discipline enriched my understanding of the meanings within interprofessional practice. van Manen (1990) suggested ways in which the researcher may gain lived experience descriptions, including getting participants to describe the event as they have lived through it; describing it in terms of the feelings and emotions it engendered; focusing on a particular event or experience; focusing on an example which stands out; drawing out how it felt in a bodily sense; and avoiding glamorising the experience with fancy terminology.

With this orientation toward the lived experience of interprofessional practice and the embodied meanings, I was able to move more toward understanding something of its fundamental nature. The lived nature of experience is of course a reflection or recollection of the experience as it was lived, it is never the same as when it occurred. "We need to find access to life's living dimensions while realizing that the meanings we bring to the surface from the depths of life's oceans have already lost the natural quiver of their undisturbed existence" (van Manen, 1990, p. 54). I was mindful of the non pre-reflective nature of the stories – stories that have already been transformed from the moment they were lived, and of the interpretive generalisations of experience offered by participants. I was also aware that the data gathered via the interview, such as descriptions of working with others and the participants' emotional responses to these experiences, as well as my questioning which was targeted toward stories that stood out for me, all enabled a base from which to investigate the experiences as lived and from which to build my interpretations and insights.

Reflecting on essential themes

A theme is considered by van Manen (1990) as the point or meaning of an experience, which may be a simplification and somewhat artificial, but allows the capturing of the nature of the phenomenon and is meant to stimulate inventiveness and insight, not contain or restrain via a mechanistic set of procedures. Reflecting on essential themes

allows for a grasping of the essential meaning of what makes the phenomenon what it is. It allows for a movement beyond facts or description toward the essence (van Manen, 1990). There is a difference between what can be seen or appears to be the case and its real or essential meaning, which requires “reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitude of everyday life” (van Manen, 1990, p. 32). Reflecting on and analysing essential themes in phenomenological research is both complex and creative, described as a process of “recovering structures of meanings that are embodied and dramatized in human experience represented in a text” (van Manen, 2014, p. 319).

The use of phenomenological themes gave some order to understanding the phenomenon and the ability to get closer to the essence or essential nature of the phenomenon in this study. At the same time I needed to heed Heidegger’s view that we can never fully grasp the essence; it withdraws as we come close, and only allows us to come closer to our understanding (Heidegger, 1927/1962).

The identification and reflecting on themes involved reading the whole of each story as well as focusing on specific parts to see what aspects of the phenomenon it revealed. Each showed a particular aspect or multiple aspects of the meaning of interprofessional practice. For each participant, I was able to bring forward the ideas and thinking within the story that seemed particularly revealing about the nature of interprofessional practice. It was in these ideas that themes emerged (See Appendix I – Example of initial interpretation).

The art of writing and re-writing

Writing and re-writing are part of the doing of hermeneutic phenomenological research, allowing language and thoughtfulness to be brought to the experience, and understandings of possible meanings to emerge (van Manen, 1990). Sometimes being able to see and extract possible meanings within the text was challenging, but as I wrote, the more it helped me see what it was I had been trying to say, bringing greater depth and clarity to the phenomenon of interest (Smythe, 2000).

Writing and interpretation began in the crafting of the stories and continued in the making sense of each of the recrafted stories. Writing was about what I could see within the text, at times not worrying about what I was writing or where I was going with it, just writing and drawing on the notions within the words. The writing and rewriting involved my beginning attempts to make sense of the text, mind mapping, a reflective journal and the

drafting of the findings chapters. These avenues for writing helped me stay connected to the meanings emerging from within the texts.

Maintaining a strong and oriented relation

van Manen (1990) suggested that some might consider the idea of orientation trivial, but alerted us to the fact that being oriented acts as a resource enabling us to always aim for the strongest, richest, deepest interpretation of a certain phenomenon. Maintaining a strong orientation toward the phenomenon of interest safeguards us from what van Manen called the superficialities and falsities that can come into play when there is a temptation to stray from the question or phenomenon. In turning to Heidegger, Gadamer and my supervisors, I was able to remain oriented, but I was also attuned to the Heideggerian notion of being ‘in-the-play’ or being open to what comes from the data and its role in showing the way (Smythe et al., 2008).

As I worked through the data, I recognised the broad and complex nature of interprofessional practice and how easy it was to get distracted from the core purpose of the research, that of gaining insights of experience that may inform education. It was in dwelling with the stories that I began to see that a greater problem in terms of staying oriented was not necessarily staying oriented to the overarching phenomenon of interprofessional practice, but staying oriented to the things within the phenomenon that mattered to the practitioners and the things that mattered to my research question. It was in coming back to the research purpose and constantly asking myself how the stories, the insights of interprofessional practice, might show possibilities for interprofessional education that ensured I maintained a strong relation to the research question. This allowed me to remain present in the journey, to listen and to see, and I began to analyse practitioner experience at a deeper level in the search for the things that mattered. In reaching for understanding beyond the narratives, and in gaining depth in my search for meaning, ambiguities, questions and continual wonder came through in the rich descriptions and exploration of meanings within the stories.

Balancing the research context by considering parts and wholes

Remaining oriented to the phenomenon, to the question of the research is important, but as van Manen (1990) signalled, “one can get so involved in chasing the *ti estin* [question] that one gets stuck in the underbush and fails to arrive at the clearings that give the text its revealing power” (p. 33). It is easy to become immersed and bogged down in writing and not know where to go to next, which is why van Manen suggested a stepping back

to look at the bigger picture, and to assess and consider how each of the parts contribute to the findings and significance of the study. This balancing of the research context by considering part and wholes, drawing on the wisdom of my supervisors and retaining an openness to the research process, enabled me to recognise when I was losing sight of the phenomenon or end goal of the research.

Establishing Rigour and Trustworthiness

Koch (1996) suggested that the legitimisation of research knowledge is dependent upon the researcher demonstrating that the research is trustworthy, through carefully considering and selecting criteria by which to demonstrate trustworthiness. De Witt and Ploeg (2006) stated that there is much dialogue and tension in the literature surrounding criteria which fully addresses the issue of rigour in phenomenological research, where rigour describes the degree to which a study is considered trustworthy. In response to the perceived need for a rigorous science to ensure the research can be trusted, Smythe et al. (2007) argued that a giving over to, and trust in, a more ontological way of understanding needs to be embraced in phenomenology, as:

what matters is not accuracy in the sense of reliability, or how the researcher came to make certain statements: what matters is what has held the thinking of the researcher and in turn holds the thinking of the reader; what calls, what provokes them to wonder. (p. 1393)

It is the researchers themselves, Smythe et al. (2007) suggested, who determine the trustworthiness of their research. This is done in dialogue with others, in testing out their thinking and in the resonance gained in the conversations with others (Smythe et al., 2007). I have felt a sense of wonder and aliveness in conversations with my supervisors, participants and peers, and a resonance when I have laid open my thinking, my interpretations.

Annells (1999) offered a way of considering trustworthiness in interpretive research, recognising multiple criteria with which to assess it, that is both fluid and emergent. Four possible criteria for evaluating phenomenological research to ensure trustworthiness were proposed, which are firmly embedded in the philosophical underpinnings of the methodology. Firstly, and of foremost concern for the researcher, is that the research product needs to be both understandable and appreciable, with its worth questioned if it is not interesting and easy to understand. Secondly, the process of inquiry needs to be understandable, where there is a clear trail of methodological decisions allowing the reader to understand the process and how decisions and interpretations were made.

Thirdly, the research needs to be useful to healthcare practice and those at the receiving end of care. Lastly, Annells suggested that there should be congruence between the phenomenological inquiry approach and the research question. These four criteria will be discussed in relation to the notion of trustworthiness in this study.

An understandable and appreciable product

The question of whether this research as a product is indeed interesting and understandable can really only be answered by the person reading it. However, I have worked to ensure that it has been written in a clear and open way and that the thinking contained within its pages follows a logical path. I sought to capture those stories which I found engaging, relevant and interesting, and have ensured that I remained as close to the participants' experiences as possible, keeping them at the forefront throughout the document. It is these stories of participant experience that have shaped and directed my interpretations.

Understandable process of inquiry

Annells (1999) made it clear that the researcher needs to provide a plainly written and clear trail outlining decisions and interpretations which render the research understandable. A discernible trail of methodological decisions is necessary in order for the reader to not only understand it, but to be able to evaluate its worth. The laying out of the philosophical underpinnings of the research and the methods that were used and align with the methodology, have been outlined in this and preceding chapters. I sought to ensure that my prejudices, thinking, and interpretations at each stage of the research journey remained understandable, open and transparent.

Usefulness of product

Another important criteria to evaluate the trustworthiness of the research, as identified by Annells (1999), is the question of the research's relevance, usefulness and its practical benefits in practice and/or educational contexts. Annells made the point, however, that only with the application of the research can its trustworthiness truly be assessed. The findings from this study have direct relevance to my role within the university, which involves leading change in relation to the development of an interprofessional curriculum within a school containing seven different health disciplines. The findings point toward a way of being an interprofessional practitioner and conditions within which these ways of being could be fostered in order to better prepare health graduates for the complexities

of interprofessional practice. It could go on to have useful application both within an educational as well as practice context, but this will be determined by those reading this thesis and the level of resonance it receives.

Appropriate inquiry approach

Demonstrating the suitability and alignment of the selected research approach to the purpose of the research, and the congruence of the chosen methods to the research's philosophical underpinnings, is the final criteria Annells (1999) recommended when evaluating the trustworthiness of research. This research sought to inquire into, explore and gain insights into the experiences of health professions working with those from other disciplines, and as such shows congruence with the chosen methodology. The research was already "in-the-midst of a specific situating that is constantly in flux" (Smythe et al., 2007, p. 1390) where "everything from our past lies within the soil from which thinking arises and bears fruit" (p. 1301). Engaging in this process has involved a dialogue between myself and the text, where I have brought my own preunderstandings to the analysis and interpretation (Koch, 2006). Along the way I have attempted to remain close to the experience itself, open to the research's emergent nature, and sensitive to the influences of my own prejudices throughout this interpretive journey. There are no such things as absolute truths; my understandings and interpretations today are forever in the process of changing (McManus Holroyd, 2007). By selecting this research methodology I have opened myself up to what Smythe (2011) calls a 'journey of thinking' and the emergence of knowing; to remember what matters.

Summary

This chapter has laid out the methods used in this hermeneutic phenomenological inquiry and attempted to demonstrate the relationship and congruence between the philosophical underpinnings and the selected inquiry processes. It has been an evolving process, one that did not come with a predetermined path, but was open to the possibilities and its unfolding journey: a journey that has enabled me to dwell, delve deeper into what it means to be an interprofessional practitioner and to broaden my horizon of understanding, to move forward with openness and to challenge my historically and culturally situated ways of knowing and understanding. The following three findings chapters reveal my interpretations of the ontological nature of interprofessional practice. It was whilst engaged in this analytic endeavour that I came to see that there were three main ways in which the participants were describing their experiences. They spoke of

those things that called them to interprofessional practice, those things that occurred during the being and doing of interprofessional practice, and those things that safeguarded and preserved this way of working. These formed the basis of my three findings chapters. It is for the reader to decide if they are understandable, interesting, useful, appropriate and ultimately trustworthy.

CHAPTER FIVE

THE CALL TO COLLABORATE: FROM WITHIN AND BEYOND

Introduction

This chapter, the first of three findings chapters, will draw on participants' stories to reveal aspects that have called them to collaborate with people from other professions. Through listening to the stories, I have sought to open a space where a richer understanding in relation to the things that call health practitioners to practice interprofessionally can be achieved. Analysis of the data reveals that a call comes from within and beyond, a call comes without thought, compelling action. This chapter will reveal circumstances when the call was responded to and when it was not, and contemplate the things that lie behind such moments. It aims to open a dialogue for considering how these things influence health professionals' engagement in interprofessional practice.

Despite the rhetoric around collaboration in healthcare, as evidenced in national healthcare policy and local strategy documents, those things that call, the connecting that occurs, and those things that safeguard and preserve interprofessional practice between and amongst different health care professions comes down to whatever concerns and/or directs the individual. This chapter will draw on philosophical notions from Heidegger and Gadamer to unveil and reveal those things that come into play specifically when health professionals act on calls for collaborative practice. The 'call' for Heidegger is as a call to action; that demands attention. Such a call sometimes comes in the midst of doing something else, but directs the person towards a concern (Heidegger, 1927/1962).

The Call to Collaborate from Beyond Self

Those things that 'called' participants from beyond themselves, called them to collaborate and demanded their attention, have been drawn from participants' stories. They show participants recognising a need to collaborate, being invited to collaborate, and describe times when collaboration was expected. The stories begin to show the thrownness of interprofessional practice and reveal different ways in which health practitioners are called and respond to the call to work collaboratively. Each story shows the call of the moment. The call is the moment when interprofessional practice begins.

The call to collaborate as a clinical need

Carol, a new graduate midwife describes working with a woman who is considered at high risk of birthing complications because of a multitude of factors including living in a remote area, her strict religious beliefs which limit her choices and other health concerns.

I have a lady who is due in about a week's time. She has health problems which need obstetric management, and her religious beliefs affect her choices. She lives rurally and there is a risk that she could deliver in the community or very quickly at hospital, with major risks at the time of birth. So there's a massive amount of communication about this client who has been seeing an obstetrician monthly, having regular scans and generally getting lots of attention because we're planning on having a smooth birthing process. Because we work in a remote and rural midwifery service, quite some distance from the hospital, there is little opportunity to attend my client's obstetric appointments. About 3 weeks ago, I ran into this particular woman's obstetrician when I happened to be visiting the hospital. I approached her because I needed to talk to her about this client and just assumed she would know who I was talking about and would be interested to know who I was. I said, 'Oh hi, I'm such and such and I'm looking after this woman'. My feeling is that I'm a health professional with a job to do, and I want to do it well, and we need to work together to achieve that. So we had a quick chat about what was happening with the client, and I was particularly concerned that the medication necessary for this woman had been ordered ready for her labour. It hadn't, so this gave us an opportunity to get the ball rolling. It was fortuitous that the birthing suite manager was also nearby so we brought her in on the conversation. She didn't know anything about this woman as yet, so it was good to let her know that we've got this person coming in and she's going to need this, that, and the other thing, here's her care plan. She could also show me where a copy of her care plan would be located, because we can never guarantee who is going to arrive first at the labour.

Carol recognised the challenges posed by the woman and was concerned about the potential risks associated with the unfolding situation. Carol equates working with others with doing a good job, and 'feels' it is her responsibility as a health professional to work collaboratively to ensure the best outcomes for her client. She knew she would need to collaborate to ensure the necessary ongoing care for this woman was provided, but was called to action earlier in the unplanned seeing of the obstetrician. She was thrown into the situation that presented itself, and was called in a way that meant the encounter was one which would take place face-to-face.

As a health professional she was aware of her responsibility to ensure the best care possible for her client. The core of her decision to act suggests that it was prompted by

her care toward the other, the woman, as well as her professional obligations informed and directed by guidelines. The call came from within and yet beyond. Her core concern, one of care, brought her awareness of the potential consequences of inaction. Her professional obligations called her to seek out others.

Carol reflects positively and ponders on the magnitude of the encounter.

It was a really productive 5 minute conversation. I was just thinking gosh if I hadn't ran into her I would have had to chase her on the phone and we wouldn't have made the links with the birthing manager either. Now everyone knows what the plan is and where to find it. I knew it would be far more effective to grab her for a couple of minutes and have an effective face to face conversation than it would be on the phone.

Carol was perhaps surprised at how productive the encounter had been; she was not only able to have her main issue of concern addressed, that of medication, but was able to achieve other things as well.

Vivian, a clinical educator supervising students on clinical placement, describes how the call to work collaboratively came from a recognition of a need to look beyond. The students were already working together in collaboration with their client, but were called to seek out others when they recognised that they did not know how to proceed with the treatment they were providing.

On this particular occasion we had a physio and speech and language therapist [SLT] student working with a client whose goal was to visit his children overseas. They were working on getting his voice loud and clear. But what would happen is that every time he made his voice go loud, his tremor got worse. He became really fixated on his tremor and really anxious about what other people thought, so was resistant to trial these voice techniques. The students were really stuck and needed to find new ways of addressing these issues. They approached a psychologist who recommended the use of mindfulness techniques. Initially they were quite anxious about this because they thought this was the psychologist's role, yet they also realised that they couldn't address the treatment goals until they had addressed the anxiety issues. They found that actually the techniques they had been recommended were not hard, they appeared to be working, the client was responding well to them and they actually felt safe using them. So the students came away feeling chuffed and quite confident and were able to continue to work on the initial treatment goals with the client.

The students, each from a different discipline, came to a point where they were unable to move forward with their client's treatment. His anxiety and resistance to push through with the initial treatment plan necessitated a different approach. They put aside concerns

around professional role boundaries and focussed on the patient's needs. The call to act was their practice challenge; they were expected to act, something needed to be done and pushed them to move beyond what was known and comfortable to them, to seek out the help of others. They showed a willingness to explore possibilities.

Thomas, a community physiotherapist, describes an experience he had whilst working in a small, isolated, rural community. He describes how the situation called for a collaborative approach to the care of the patient, because of its complexity and uncertainty.

One case I remember was a woman who had had a fall. She was still in her home, which was a totally inappropriate environment, two storey property, horrible stairs all that sort of stuff. Her daughter had phoned up from London and we realised we needed to get her into hospital that night. We realised that while we were out there, one of us was going to have to be liaising with the social worker, one liaising with the NASC [Needs Assessment and Service Coordination] team, and one was going to have to be calling the GP, so we both needed to be out there to do that sort of case management role. It was a really fun and supportive environment to work in.

In this situation described by Thomas, there was uncertainty about how they might find their patient and what the intervention might need to be. Not only did the uncertainty of the situation come into play in their decision to collaborate in relation to her care, but there may also have been recognition of the need to provide support for each other; to share the responsibility.

In the stories above, the call to collaborate came from the presentation of a clinical need. The need that each participant recognised called them to seek out and gain the support of their colleagues from other disciplines. The participants acted out of concern for their patients, and perhaps their own need to be 'seen' as ensuring safe care was provided.

The call to collaborate as expectation

The call to act collaboratively is often already there, dictated by and expected within a context. In this story Amanda, an emergency medicine doctor, talks about how the coming together of health professionals in an emergency situation was an expectation from beyond, but also within.

I work in an emergency department, which is very much a team environment. The team were called to a daytime resuscitation. The patient had an arrhythmia and arrived with the paramedics, there were emergency medicine doctors, nurses, the medical registrar, a cardiologist, an orderly and a health care assistant as well. There is a very clear prescribed algorithm to follow for a person with arrhythmia.

Having a common goal, or a common mental model, absolutely brings the team to the same space that can pull everything together. Everyone knew what they were doing and had an awareness of what other people were doing. Despite the outcome for the patient ... the patient died, I think they did have the best opportunity, if there was any opportunity to have survived, the patient would have. I still think it really was a successful resuscitation.

The patient arrived critically ill and required an immediate response. The call to action in this case could not be ignored; there was an expectation to respond to the call, it was seemingly without choice. This team of people were thrown into the situation. They were not thinking about themselves, their focus was on saving the person's life; the life and death nature of the team encounter focussed their attention on what needed to be done for the patient. There was no time to be concerned or dwell on issues related to professional boundaries, personalities or power; they were caught up in the moment and the pre-prescribed plan of action. The call to act, although expected in this context, was also instinctive, arising out of concern for others. This was an expected response within the emergency care setting; an integral part of Amanda's role and the role of the other health disciplines represented. The situation called for all of these hands, a certain mix of professional skills, perspectives and experiences to provide thorough care.

'Being-in-the-World' and 'being-with-Others' calls us to act out of 'Care'. Furthermore as health professionals there is a clear expectation to fulfil a range of prescribed roles with care and compassion. Aspects of the care given to this patient were pre-prescribed, by way of algorithms, but not all aspects of the caring are or can be prescribed. Amanda seemingly had no choice to act, but she could choose to what extent she cared or acted compassionately toward the patient and her colleagues. Who she is, her being-in-the-world, her mood and comportment direct how she shows care. How people deal with situations will depend on their mood and/or attitude toward it and whether they choose to engage in it or overlook its demands (Gelven, 1970).

Amanda described the busy scene that had the potential to be chaotic and stressful, as one where everyone worked to a prescribed way of doing things. There was the call to respond to the emergency and an expectation to act according to known ways. Despite its thrownness, the situation and the response from the team were not new. The team already knew what to do. They knew what others had to do. The knowing comes from having experienced emergency resuscitation situations before. It comes from having had resuscitation training. It comes from having clearly defined roles. It comes from following a prescribed algorithm. Staff have come into the encounter with fore-having;

an advance understanding that is used to make sense of the situation (Heidegger, 1927/1962; Smythe et al., 2008). Was responding to the call in this case facilitated by this knowing? Perhaps they came with the reassurance that the prescribed roles and algorithm would assist the team to work together and give the patient the best possible chance of survival?

In addition to this knowing what to expect and drawing on previous resuscitation experiences, having trust based relationships and awareness of others' strengths and weaknesses in the team was described by Amanda as contributing to how well the team worked and created an ease in the working together. Did knowing each other and the already-there relationships amongst the team contribute to a willingness to be called into collaborative encounters again and again? Acting or choosing to act collaboratively may be prompted by this sense of comfort and ease which comes in knowing others and having some awareness of what they bring to practice. Despite the outcome for the patient in this case, Amanda still referred to the encounter as successful. She felt that the best was done for the patient.

The call to collaborate as an invitation

Vivian, who had recently started work as a speech and language therapist with an established neuro rehabilitation team, was outside of what was familiar and known to her. The call to collaborate came from being invited by another health professional.

I started working with a young guy who had a brain injury who hadn't yet got his voice and had just had his breathing tube removed. There was this phenomenal physio, I'll always remember her, she was German and said to me, 'Let's do this session together'. I was terrified thinking how was this going to work? I had no idea. I felt a bit intimidated by the knowledge and confidence of the health professionals on the rehab ward, particularly the thought of them watching me and thinking that I wasn't doing things right. She asked me what my goals for the session were and I said it would be good to get some voicing. She then said 'Ok, I want to also look at transferring, balance and breathing, so we could try different positioning for breathing to assist with his voicing'. We found some common ground and were able to support each other in achieving these goals. I learnt about some breathing techniques that I could use in the future and she learnt some things as well. She coached me along and provided the structure and a framework for the collaborative session. I came away feeling really excited. It was a positive experience which had some really good outcomes for the client, as well as for me.

The 'being called', perhaps initially invoking fear for Vivian, was an invitation to move beyond the fear. It challenged her previous understandings and ways of working. Perhaps

Vivian's fear was sensed by the physiotherapist, which may have prompted the 'being called', the 'invitation' and the manner in which this was carried out by the physiotherapist. The way of the 'being called' was powerful. Powerful in the sense that the person calling her was someone she looked up to, she viewed them as 'phenomenal'; but also in the way the calling was carried out – with care and concern, with questioning and a common purpose. Overcoming her fear and yielding to the call would allow her to move closer to the confident and knowledgeable health professionals she admired as well as overcome her fear of being exposed as incompetent.

Did Vivian acquiesce to the call because she felt in safe hands? She sensed the physiotherapist's comportment, as a supportive, knowledgeable and competent coach. She was not being instructed to work in this way, but may have sensed that the *knowledge and confidence* comported by the health professionals in this team had, in part, come from a particular way of working. This was a living experience of a collaborative approach to the care of these clients that may have directed how she felt she ought to respond. The directness of the 'being called' and methods the physiotherapist used to engage Vivian, allowed her to participate, broaden her horizon and begin to enjoy the encounter.

Her interaction some years ago with this physio has always stuck in her mind. She has never forgotten the influence of the physio on her practice. For Vivian, it opened up a new world of interprofessionalism. The positive experience of collaboration, the 'learning how' to work collaboratively provided Vivian with a framework for how she might approach collaborative practice in the future. Her positive experience went ahead of her (Heidegger, 1927/1962) to be drawn on in similar situations. She could see the benefits of working collaboratively for the client, but she could also see how it helped her learn and develop as a therapist. There was mutual learning and support which made her feel good. It set the scene for her future practice, which calls her to work collaboratively. She could move forward and draw on this experience to shape and frame other interprofessional encounters.

The call to collaborate for Vivian came initially from the invitation. This moment stands out in her mind, when she was first called and began to practice in new ways; collaborative ways. She is forever changed by the encounter. The way of the 'being called' is of considerable significance. It was done in a way that was supportive, respectful and mutually beneficial. She now no longer needs to 'be called'. The initial invitation to practice collaboratively showed her a different way of practicing; a way

which she now feels excited about and actively seeks out. The call to her now is intrinsic; it comes from within and she has become the caller, inviting and supporting others to work differently, to collaborate. This is evident in the next encounter where Vivian recalls inviting and supporting another health professional to work differently.

When I was working at a regional rehabilitation unit for adults with acquired brain injury following stroke or traumatic brain injury [TBI], I recall an encounter with one of the registrars who was fairly new to the unit. This particular client we were working with had aphasia following a stroke and the registrar was needing to gain sign off on the enduring power of attorney documentation. He approached me to ask if I would help him communicate with this client, basically to act as a translator. I didn't think this was a good use of my time and thought the time would be much better spent training him up. I said 'Why don't you come and sit in on one of my sessions and observe the techniques I am using?' He was initially hesitant at the idea, which came across as a little defensive, but he joined me and even had a go having a conversation using this technique. He fed back to me a couple of days later that he had had a really successful conversation with this particular client and, with the lawyer present, had signed off the required documentation. He was happy from then on to use the techniques he had been taught with other clients. He kept coming back to me days, weeks, months down the line all excited because he'd had this lovely conversation with his clients. Through providing him with a safe and supportive environment in which to observe and practice certain techniques, he was able to relax and realise that actually it is ok not to understand everything the client says and it can at times be uncomfortable, but that he has the skills to do it himself.

This story shows how interprofessional practice is about the value that the patient can receive when health professionals learn from one another and how things can be done differently; through active communication and the sharing of expertise.

Vivian was sufficiently confident in her role to recognise that what she was being asked was not the best way to manage this or future similar situations for the client, the doctor or other SLTs from whom he might choose to seek support. Being able to communicate with people with aphasia would be beneficial to many people and Vivian wanted to share her knowledge. By sharing these 'ways' of communicating, the client and health professions benefited. Vivian invited the registrar to engage in a collaborative learning opportunity and was called to take on a collegial role in his coaching. The doctor was called to collaborate in a different way to what he had envisioned. He had called for help, but not the sort of help he ultimately received. He came away from the collaborative encounter having gained something valuable for his future practice. He also, perhaps, came away with a new understanding of teamwork and collaboration. In this interprofessional mode, working together does not necessarily mean getting others to do

things for you, but working and learning together, supporting one another to do the best for the patient. Vivian knew this, and that is what called her to respond differently to what was expected.

Amy, an occupational therapist working in palliative care, talked of working closely with a physiotherapy colleague. In her narrative she described how the relationship invited a collaborative approach to practice. She and her colleague opened themselves up to the possibilities of collaboration from which their relationship was formed.

When I was locuming in a community based palliative care service, I worked really closely with a physio. We came to know each other through reading the shared client notes, seeing what each other was doing and having those casual conversations, 'Oh so you're seeing such and such, so am I, well what have you noticed, what have I noticed' ... so that kind of formal and informal collaboration that happens. There was just a respect and acknowledgement on both sides and a clear focus on the client and getting the best outcomes for them. Yeah, so that was really nice. It helped that we had an existing open, positive, and respectful relationship, so we knew one another and how each other worked.

The call for Amy came from those initial conversations where she sensed the possibilities that working together might have for her clients. Amy describes almost a dance focussed around the patient, where there was a too-ing and fro-ing between these two health professionals; a getting to know each other. There was a respect for, and an awareness and understanding of each other; of each other's unique and shared roles and responsibilities, of the common purpose, and of the best way to work together for the client. It was these formal and informal encounters that invited them to work together and the knowing of one another that facilitated the working together. They knew this collaborative practice relationship worked and it 'called' them again and again. If you know what you know, you cannot erase it, it is already there and you are compelled to act on it. "When we have had an experience, this means that we possess it. We can now predict what was previously unexpected" (Gadamer, 1975/2013, p. 362). Gadamer goes on to talk of the impact of having had an experience: "The experiencer has become aware of his experience; he is 'experienced'. He has acquired a new horizon within which something can become an experience for him" (Gadamer, 1975/2013, p. 362).

Amy knew that working together with the physiotherapist was going to provide the best possible outcomes for the client. In the getting to know one another, in the shared sense of understanding that developed, so did the call; it compelled her to practice collaboratively.

Interprofessional practice by its very nature is a ‘being-with’ others in the world. In those calls to collaborate where participants have responded, there has been a common purpose; an openness to, and a learning about, others; where understanding, respect and trust in others grows and brings with it an openness to the possibilities of collaboration.

The Call to Collaborate from Within

For Heidegger, Dasein as the caller summons itself, the call comes from its consciousness toward its ‘potentiality-for-being’; the call for care “Dasein is at the same time both the caller and the one to whom the appeal is made”, the call brings Dasein to that with which it cares. “The call comes from me and yet from beyond me” (Heidegger, 1927/1962, p. 320).

A call from within is a call that summons Dasein forth toward something, a call which is heard and understood without words, a call that says nothing, but from which an understanding of what is called just is (Heidegger, 1927/1962). Such calls will be discussed in relation to three notions: solicitude, prejudice and mood.

The call as solicitude

Heidegger described Dasein as a solicitous entity, where concern for the well-being of others is part of Dasein, coming before indifference or self-interest (Giles, 2008; Heidegger, 1927/1962). How solicitude shows itself as ‘care’ in the call to act collaboratively, is revealed through some of the participants’ stories of working together. The following narrative from Ricardo, a nurse working in mental health, shows his solicitous nature; his concern for others guides the manner in which he chooses to engage. Ricardo’s solicitude drives his desire to get to know, better understand and learn from others.

The main thing I enjoy about nursing is just the way of dealing with people. I’ve always been a people person. I’ve always wanted to meet, or just learn from people, learning who people are. I think there’s a lot of value in that. Because the more you meet people the more you can enrich yourself, because you get to experience a life that you couldn’t possibly have experienced if you hadn’t met them. Working as a nurse, you deal with so many patients, with so many different backgrounds. You get to experience the hardship that they’ve gone through, how messy their lives have been, and comparing my life with them I’m quite privileged actually. You just get to appreciate that the more you go through life the more accountable you are to your own actions, yeah.

Heidegger would say “it is true that in everyday being-together-with-others, this primary understanding of the other, as well as of oneself, is often covered over and distorted, so

that to know each other requires a “getting-to-know-one-another” (M. King, 2001, p. 76). Ricardo is called (calls himself) to get-to-know-others, and in the getting-to-know-others he shows his solicitous nature. This solicitude, the call from within, drives his actions and how he comports himself in caring for others.

In solicitude Ricardo shows a way of ‘seeing’ the other, a way of seeing which allows him to better understand the other as well as himself. In this narrative Ricardo seeks to understand others by learning about their background; he actively seeks to enrich this understanding. Heidegger would call this authentic mode of care-for, ‘Rucksicht’. Rucksicht, in caring for someone, is a considerate regard that comes from looking back upon the person’s world, a world that needs to be taken care of, for and with the person (Heidegger, 1927/1962; M. King, 2001). Looking back at the person guides his future actions in his authentic caring. What is also somewhat evident in this narrative is an understanding that lies in looking toward something, another way of ‘seeing’ which Heidegger calls ‘Nachsicht’. It is a way of seeing the other which helps the person move toward managing and caring for his/herself. There is a sense that Ricardo understands the need to care for another requires both a looking back at where the person has come, their past/previous experiences, in order that he may better prepare them to manage, to care for themselves toward the future.

In the story that follows, Ricardo outlines what might be considered a usual or common encounter between health professionals and patients, where an overt role of the health professional is one of care. This story shows how both ‘Rucksicht’ and ‘Nachsicht’ come into play in the team’s attempts to both understand the family’s concerns and in supporting them to move forward, to manage the situation for themselves.

When I was working in psych liaison there was this young woman who overdosed herself because she broke up with her boyfriend. She was in the intensive care unit and there was a lot of neural damage, she wouldn’t be able to function as she had before, she couldn’t speak, her affect was quite flattened, and her mobility was limited as well. Her parents were angry because apparently they’d been told mixed messages and wanted to lodge a complaint. Psych liaison was asked to assess her. There was myself, a registrar and a consultant that met with the mother and father and the conversation lasted for, gosh, two hours and pretty much the end result was really good because the family had a lot more peace in their heart, peace in their situation with their daughter and came to the acceptance that she won’t be as she was before. It was clear that there was really limited communication between the family and the main treatment team, they were really quite frustrated, but this shifted to, okay we’re not going to complain anymore and thank you.

The liaison team recognised and were called to act out of the family's distress. The team's considerate regard in this case 'Rucksicht', was revealed in their choice to sit down and listen with the family. Care was shown in how the team took the time to listen, in the recognition that understanding lay in the looking back and hearing the family's concerns. The team were looking toward a family that was able to understand and support their daughter in her recovery, 'Nachsicht', helping them to understand her situation and be able to manage it themselves as they moved forward. They were attuned to and remained engaged in solicitude. The story revealed a giving over of themselves to the needs of others, not giving themselves over to self-interest, or being constrained by the environment, time.

Many factors would have been in play that precipitated the family's distress, not least their concerns for their daughter. How did the initial team involved in caring for their daughter show their solicitude; in what way was it manifested? Was there an overlooking and un-noticing of the family and their needs at this stressful time, which meant that another team had to be called in to manage the situation? Could this have been avoided in the solicitousness of practice? How in the business of caring for critically ill patients does solicitude find its expression? Is it in the giving of time, the sitting down, the listening, the reassuring, and in the holding of the others hand, that care is revealed and is felt by those receiving the care?

Heidegger refers to deficient or indifferent modes of solicitude which describe the everydayness of being-with-one-another and may manifest as a passing-one-by-unnoticed, an overlooking of the other, or could be more overtly demonstrated as in the example Ricardo gives below.

There are some professionals, especially the psychiatrist, who can have a lot of ego. There was this one instance when he was checking bloods and one of the forms dropped. I was behind him, a bit far away and he kind of beckoned me to pick it up. I was like 'dude you dropped it, you're there, I'm not' you know. So after that I'm like 'whatever!' I did pick it up, but I think that's my culture, that's just part of who I am, just for the sake of things to flow on. Also because the patient was there and the phlebotomist, we were all cramped in that one space and to have that awkwardness sitting in the front of the elephant, you know, it's one of those things that just make you think.

In the everyday being with others in the world, solicitude is manifested both in its positive and deficient modes, much of which is hidden in the everydayness of being. The psychiatrist demonstrated the deficient mode of solicitude which revealed itself as one

of inconsiderateness or a disregarding, a disrespecting of the other. It also revealed Ricardo's solicitous nature, one which was bound up in being-for-the-sake-of-others and an authenticity toward himself (Heidegger, 1927/1962). Ricardo's care for others, and who he is, his authentic being, reveals his concern for others in the room; for the patient and for the phlebotomist, pointing toward perhaps why it is that practitioners often accept certain behaviours, to keep things *flowing* for the patients.

The call; prejudiced

Prejudice is a precondition of understanding and determines how people approach and understand the world (Gadamer, 1975/2013). It is defined by Gadamer (1975//2013) as "a judgement that is given before all the elements that determine a situation have been finally examined" (p. 240). How the world is acted upon and understood is governed by prejudice and the preunderstandings that are brought to it. Preunderstandings can be subconscious or unconscious, remaining hidden and difficult to reach (Nyström & Dahlberg, 2001). They may constrain or facilitate understanding but whatever the case, people cannot escape the prejudices of their preunderstandings; their current understandings are influenced by them (Debesay et al., 2008).

How health practitioners view and respond to calls to work collaboratively is rooted in each person's historical and cultural context; their previous experiences and the preunderstandings they bring to the encounter. People's historical context prejudice their interpretation (Gadamer, 1975/2013; Sharkey, 2001). What they think about themselves and others will influence whether and how they respond to calls to collaborate, constraining or facilitating interprofessional practice. Carol, a midwife out visiting a woman who became seriously ill, illustrates the differing interpretations of the situation between herself and the paramedics she called upon.

Quite a common minor niggle that comes up from time to time is when we're needing to use an ambulance to transport somebody usually in labour to the hospital for whatever reason. Sometimes it can be quite a hard situation to deal with and sometimes I can feel quite uncomfortable. I needed to transfer a woman who'd had a caesarean about 10 days earlier and had acquired a serious wound infection. My midwife partner had drained about 500mls of pus out of her caesarean wound and she had a temperature. So I'd called this ambulance and said it was time critical, not life threatening but time critical because she needed to be in hospital now, she was actually very sick. If I hadn't said it was time critical, because of her remote location, it could have taken up to 2 hours for the ambulance to arrive. When the ambulance did arrive, it was a difficult sort of driveway and they had got as far as they could, so I said she could walk to the

ambulance, you know because she could. It was at that point I got the feeling, and the 'look', like, 'in what way is this time critical?' I know they must see far messier situations, but they're not necessarily recognising how sick somebody is when we say that they are. Mostly they just make you feel like that, they don't tend to say 'are you sure you really needed to call us?' directly. Often we get, 'are you alright back there?' while they sit up the front and not pay much attention to us. You just have to get on with it and recognise they don't necessarily know why I've made my decisions, but they stand.

In the telling of her story, Carol's concern for her patient was evident, and her concern about what the paramedics might think of the seriousness of the call was almost palpable. This concern influenced how she made the call and the language she used. She was careful in her choice of words to ensure a prompt response. She made the assumption that unless she chose her words carefully, they may not understand the seriousness of the situation and delay their arrival.

Carol's instincts, her feelings and her observations told her that the paramedics too had made a judgement about the seriousness of the patient's condition and about the midwife who had made the call. Their opinion was evident in the look they gave, their choice to sit up front, and the things that remained unsaid. There is a sense from the story that Carol feels undermined; that her clinical judgement is being questioned; a sense that the paramedics may have felt it was a lower priority and that calling an ambulance was overly hasty given the patient could walk to the ambulance. Each made an interpretation of the other that came from their acquired horizon. Gadamer would say that "we are ceaselessly in a present through which the past speaks" (Lawn & Keane, 2011, p. 53). It is through tradition that our attitudes are determined and thinking is carried out within this horizon (Gadamer, 1975/2013). Carol drew on her knowledge of infectious processes, her knowledge of her client, her previous experience with the ambulance service, her need to ensure best care. Further, she needed to adhere to protocol and service or professional guidelines, draw on her 'sense' of the situation and much more besides in the making of the 'call'. Her preunderstandings, her prejudices, had shaped how she chose to act in this situation. The phone call Carol made, as well as her choice not to challenge the perceived existing horizon of the paramedics who responded to her call, was based on her preunderstandings.

Gadamer (1975/2013) stated that to bring these differing horizons closer together to expand the range of vision of those involved requires openness. Such openness means that "when confronted with new experiences we will be able to see 'the otherness' of the phenomenon ... that is not already existing in our preunderstanding" (Nyström &

Dahlberg, 2001, p. 341). If the opportunity to unpack the situation and to engage in dialogue had arisen between Carol and the paramedics, it may have gone some way toward overcoming the prejudices of those involved and expanded horizons of meaning.

Jocelyn an occupational therapist refers to how a negative experience and her interpretation of the experience as a junior therapist working with another health professional was significant enough to have influenced her choice of career for over 20 years.

That experience as a basic grade OT [occupational therapist] had an influence on what I wanted to do next and what I wanted to do was get out of the inpatient environment. My next job was working in rural Leicestershire where I had no contact other than by telephone or letter with doctors. I was autonomous and worked in a team with other OTs, social workers, OT assistants and was working in people's own homes which I really enjoyed. So, for me, I think it had the effect of not wanting to expose myself, to that hierarchical, patriarchal culture. And I stayed out of inpatient areas, until 2008.

Jocelyn was conscious of her prejudices which had formed following a previous significant experience and shaped how she chose to practice in her future. This awareness of her prejudices, which revolved around not wanting to work in hierarchical and patriarchal environments, allowed her to cautiously make the transition back into a practice area she had avoided for over 20 years.

And I think one of the things that shocked me about going back into an inpatient setting, it's the first time I'd been in an inpatient setting in New Zealand, was how little the culture had changed. In this particular hospital I saw a siloed, patriarchal culture with the same issues of the doctors being treated as a special case in the whole environment. Of course that pressed my buttons, because I feel that we should be working in a way that acknowledges the different skills and knowledge that people bring to a team.

The experience in her past shaped her views on how healthcare should be delivered. Jocelyn believed that there was no place for siloed practice, a patriarchal culture and elitism in healthcare and was *shocked* that it was still pervasive in practice. She did not want to see people being treated like she had been, and was firmly of the belief that there should be an acknowledgement of the skills and knowledge that different disciplines bring to healthcare. Her understandings have come about because of the consideration and negotiation of her past and present horizons and have softened with age.

What I discovered there was, I was 30 years older and found that this was really quite valuable in some of my interactions with some of the doctors. I also feel as

though I understood a great deal more, I am much more compassionate about the pressures that the younger doctors are under, and I saw a lot of bullying behaviour for the younger doctors. I didn't experience being bullied or intimidated because I refuse to be intimidated at my age.

The limits of Jocelyn's understanding after the negative experience she refers to were within a certain horizon of understanding. Over time her horizon of understanding has expanded which has to some extent enabled her to overcome her prejudices. She draws on her more recent experiences to interpret and understand what it means to work in the context she had previously avoided. Jocelyn's awareness of these prejudices, her drive to examine and overcome them and to look beyond her horizon of understanding mean that she is now better positioned to be able to respond to calls to work in these environments with other disciplines traditionally bound in hierarchy.

The call as mood

Being-with-others in the world means that people are often governed by conditions and situations beyond their control (Gelven, 1970). Heidegger (1927/1962) would describe this as thrownness, a part of everyday being-in-the-world, giving the example of being born into the world without choice or planning, being thrown into circumstances as a part of the everydayness of being-in-the-world-with-others. Dealing with this thrownness is directed by their state of mind which shows itself as mood; as feelings; as being attuned. "A mood makes manifest 'how one is, and how one is faring'. In this 'how one is', having a mood brings Being to its 'there'" (Heidegger, 1927/1962, p. 173). Mood is always present; it is the ontic manifestation of attunement and Dasein is always 'tuned' into the things that matter (Heidegger, 1927/1962). Being in a certain mood is to be attuned in a certain way, determining the way in which the world is viewed and the way it is engaged and responded to. Mood for Heidegger cannot be controlled like an emotion or behaviour, but it can influence whether they choose to turn away from the situation or whether to respond to its call and consider its possibilities.

Amanda reflects on experiences in her past where she has felt belittled by the actions of others. What mattered to Amanda was doing a good job. When she is tuned into the things that matter to her, she is more susceptible to the disclosing power of mood, which effects how she 'is' in the world.

There's no doubt that for most people, it's easiest to do your best and be your best and see most broadly, when you feel safe to be appreciated and valued. There have certainly been lots of situations as a student and as a younger doctor where

I have felt belittled. It makes me lose focus, it becomes a lot more about me and what I have done wrong or how I could have done better. Whereas when I'm feeling the other things, it doesn't have to be about me at all because then I can just focus on the patient really. When I'm focussed on me for whatever reason it's easier to make mistakes or not pick up on things or my focus narrows. My attention narrows. I'm not able to think of other possibilities or have a broader perspective in terms of diagnosis or other things going on. I think that it really cramps down self-reflection and being able to look broader. It would certainly clamp down any possibility of me asking any questions or giving any suggestions or even thinking them as I'm too busy licking my wounds to be worried about anybody else's.

Amanda describes how her mood, her feeling of being belittled had an impact on how she engaged with the world; her being-with. "Letting something be encountered is primarily circumspective; it is not just sensing something, or staring at it. It implies circumspective concern, and has the character of becoming affected in some way" (Heidegger, 1927/1962, p. 176). Amanda's state of mind, her mood, affected her ability to do her job well, to turn toward those things that mattered. Her mood took the focus from the patient toward herself and impacted on the care she provided. There was a turning away from what mattered, the care required for the patient. The call to care was affected by her mood.

It is a different mood that allows Amanda to work at her best, a mood that comes with feeling safe and valued because "when we master a mood, we do so by way of a counter-mood; we are never free of moods" (Heidegger, 1927/1962, p. 175). Responding to calls to work collaboratively will depend on a person's mood and their ability to deal with the thrownness of the situation.

Solicitude, prejudice and mood are equiprimordial in nature; you cannot have one without the other; there is cross over between them. They cannot be identified as different calls, but shine light on the things that come from within that influence responses to calls to collaborate.

Summary

This chapter has pursued the things that influence health practitioners in the turning toward or the turning away from calls to collaborate. Participants' stories have revealed that calls come both from beyond and from within. How they interpret and respond to calls to work collaboratively is dependent on who they are; the nature of their being, and permeates all aspects of being-in-the-world. What calls health professionals to come together in the care of a person, the beyond and the within aspects of the call and the

response to the call, cannot be seen as separate entities. They are all part of Dasein's Being-in-the-world.

Calls from beyond come in the thrownness of everyday practice when a need presents itself. Such a need may manifest as uncertainty in how to move forward in the care of a patient, as urgency in life critical situations, and in the complexity that comes with addressing the multiple needs of those with long term conditions. Participants identified and responded to a need for additional input and support beyond what they could individually provide; beyond their scope, in order to ensure the best possible outcomes for the patient. Instilled within them was a sense of responsibility that comes with being-in-the-world-with-others, driving them to act when a clinical need presented itself. In the thrownness of everyday practice they are called again and again to ensure the patient receives best care in the safest possible manner.

Calls to work collaboratively are often already there; as an expectation; as just what 'is'. This is an expectation that cannot be ignored, one that is prescribed and comes with an accepted framework or one where there is no other choice but to act in this way. Such expectations are dictated by their thrownness. In contexts where the call to work collaboratively just 'is', and where these calls have resulted in positive experiences, there is a sense of ease where the call to collaborate is no longer a thing that needs to be called, it just becomes how it is.

For some, being called or invited to work collaboratively outside of expected collaborative practice frameworks, can create unease. Unease, perhaps from a lack of previous experience of interprofessional working, an unease because it may challenge existing uni or multidisciplinary ways of working, unease because of a sense of vulnerability that comes from having to open oneself to others and a fear of 'being exposed'. How the person is invited to collaborate and who is doing the inviting appears important here. A sensing of the possibilities for the other and themselves, an openness to move beyond one's own horizon, a getting to know others, trust, mutual learning and having a common purpose were things revealed in the stories that prompted a turning toward the call. Focusing on the patient is the central tenet of interprofessional practice and once this was understood and manifested by those involved, it shifted concern away from the health practitioner, enabling him/her to turn towards and act on calls to collaborate. In the turning towards, in the learning how and the positive doing of interprofessional practice, it becomes intrinsic, an automatic response to providing patient care.

Calls from beyond have been revealed as coming from a clinical need, from being invited and where there is an expectation to collaborate. However the person being called is also the caller. The call comes from beyond but also from within. How someone interprets and understands the world will influence whether they call themselves forward to act collaboratively, and how they respond and act in and on their world. It is a result of a complex interplay of Dasein's Being-in-the-world, of solicitude, of prejudices and preunderstandings and of mood. Care for others guides the manner in which people choose to engage and is shown from participants' stories in the getting to know others, in the considerate regard that comes with a looking-back as well as a looking-toward the future of the other; a 'seeing' as a way of understanding.

Prejudice, and the preunderstandings or assumptions which underpin it, shapes how people interpret and make sense of a situation. They can work to constrain or facilitate calls and responses to collaborate. Prejudices sit within an acquired horizon. Without an openness to new experiences or to others, the differing horizons will not be expanded or brought closer together. It will limit their understanding (Gadamer, 1975/2013). "A person who has no horizon does not see far enough and hence overvalues what is nearest to him" (Gadamer, 1975/2013, p. 345). An awareness of the preunderstandings and prejudices one brings to an encounter will expand the person's horizon and allow them to engage in the dialectical process of coming to understanding; of interprofessional practice.

Another dimension from 'within' is how one 'is' at any particular moment; one's mood. Mood is disclosed in relation to those things which matter to a person and affect how they go on to engage with the world.

The call is in relation to what health practitioners care about. The essence of the call involves such things as:

- how pressing the clinical need is
- how aware the practitioner is of his/her own limitations to provide the necessary care
- how the call is made
- what the expectations are
- previous knowledge or frameworks for how to do it
- previous positive experiences which call again and again
- a practitioner's mood
- what they care about

- what prior understandings they bring to the encounter
- how aware they are of these presuppositions/prejudices
- how open they are to expanding their horizons through the dialectic process of understanding with and about the other.

This chapter has unveiled some aspects of the meaning of interprofessional practice though exploring the essence of the call. Being called to work with other health professionals is the first step toward interprofessional practice.

CHAPTER SIX

IN THE SPIRIT OF INTERPROFESSIONAL PRACTICE

Introduction

Working with others in healthcare is an essential and expected part of providing care; its ordinary everydayness is also taken for granted. Its complexity is overlooked and more often than not remains hidden. There is a sense that when it is working well, or is described as ‘good’, those engaged in it are working in a spirit of interprofessional practice. The stories selected in this chapter, reveal features which may in fact point to the heart of interprofessional practice; features which may determine the success or otherwise of the interprofessional encounter.

Spirit has been defined as an inner quality or nature of a person; a special attitude, outlook or frame of mind; a feeling or disposition characterising something; an essential principle which influences a person (“Merriam Webster Dictionary,” 2016). What things show themselves as being in the ‘spirit’ of interprofessional practice? Interprofessional practice encompasses much more than recognised, observable and measurable competencies such as ‘interprofessional communication’, ‘patient centeredness’, ‘interprofessional teamwork’, ‘role understanding’, ‘interprofessional leadership’ and ‘conflict resolution’ (Canadian Interprofessional Health Collaborative, 2010). Although interprofessional competencies represent vital skills for interprofessional practice, the participants’ stories illustrate how the spirit with which the person enters into and engages in interprofessional practice is both complex and central to positive outcomes. Working in a spirit of interprofessional practice implies an inner quality, an attitude or inclination that supports and enables the development of relationships that promote working together in a more connected way. Being able to fully grasp those things that influence interprofessional practice is challenging, as the spirit with which someone engages is hidden and subject to the thrownness of everyday practice.

In considering a particular phenomenon, in this case ‘interprofessional practice’, Heidegger asserted the need to understand it in its being; a person cannot exist in the world as a disembodied spirit because his/her thrownness into the world forms his/her spirituality (Heidegger, 1927/1962; M. King, 2001). Spirit in this sense is Dasein; it is in the being of Dasein; “Everything we talk about, everything we have in view, everything

towards which we comport ourselves in anyway, is being; what we are is being, and so is how we are” (Heidegger, 1927/1962, p. 25). There are many dynamics that come into play in interprofessional practice; through one’s being and the being of others encountered in being-in-the-world, which is always within the context in which the encounter takes place (Heidegger, 1927/1962). Interprofessional practice is relational and the stories reveal the implicit relationship based nature of the interprofessional encounters described. What reveals itself as drawing people together, enhancing the interprofessional relationship is the spirit into which people enter into and engage in such encounters. This may be what matters most.

A common feature that shone through the stories was how the health professionals involved all paid attention to the patient. A focus on the patient seems to be at the heart of working in a spirit of interprofessional practice. Other aspects that have shown themselves as being significant in these collaborative encounters that could be described as working in a ‘spirit of interprofessional practice’, point to notions such as: getting to know others as health professionals and as people; comporting oneself with an openness and respectfulness; trust; and engagement in genuine dialogue. These dimensions of working with an interprofessional spirit cannot be considered in isolation; there is an interrelationship between each, and one cannot be separated from the other.

Through listening to the stories, I have sought to open a space where what matters in terms of what I perceive to be ‘good’ interprofessional practice comes forward and a richer sense of knowing is achieved.

The Spirit of Interprofessional Practice as Patient Focussed

Patient/family centred care is a philosophy of care which is universally employed in western healthcare environments and health education programmes (Ferguson, Ward, Card, Sheppard, & McMurtry, 2013). The underlying philosophy of care directs practitioners to understand the patient as a person, which includes consideration of his/her values, beliefs, being present, and providing for his/her physical, emotional, social and spiritual needs (Pelzang, 2010). Despite its ubiquitous usage, there remains a lack of agreement on what patient centred care actually consists of (Lévesque, Hovey, & Bedos, 2013; Wyer, Alves Silva, Post, & Quinlan, 2014).

Irrespective of these academic debates, patient centred care in action is particularly prominent in Amanda’s experience of ‘good’ teamwork, which hinged on a clear and compassionate focus on, and communication around, the patient. How to do the very best

for the patient was at the forefront of each team member's practice; not individual egos, departmental expectations or other personal and professional distractions.

There are patients who have presented at the emergency department where a part of their being there is abuse or suspected abuse and the role of the team, particularly social work and psychology is really important. The couple of examples where the team worked really well, was when everybody worked together for the patient, the nurses, social workers, psych, and also the police and detectives. The people involved all had a focus on the patient- how we could minimise her damage and maximise her care, and the communication revolved around that, rather than their own egos, or what worked for the department or other things.

Amanda describes how this collective and compassionate focus on the patient, to minimise damage and maximise care, allowed the team to communicate and collaborate. The shared focus in this case directed the team, their conversations, their plan and their actions. It called them to behave in ways that suggest a readiness and openness to finding the best way forward together. The team Amanda describes was made up of a range of people coming together, maybe for the first time. They may not have had the benefit of knowing each other beforehand. Nonetheless, they were united, working in unison. Being defensive or distracted by other things was superseded by a shared concern for the patient and what was best for that person right there, right then. This is not always the case, as Amanda describes:

Often times some of those conversations can be defensive and people say things like 'surely that didn't happen' or trying to prove somebody wrong rather than just looking after them and listening to their story, and worrying about whether it's right or wrong or who is at fault at another time. In this situation there wasn't any of this defensiveness and I think it worked really well. There really was a focus on 'how can we care for this person' and still the other things need to happen, but they all kind of happened with the compassionate care focus on the patient.

The group of practitioners involved in this person's care did not come with their own agendas. They listened to and focussed on the person's immediate needs. This, along with a compassionate attitude, ensured that the collaborations within and amongst the team worked. Amanda suggests that having a patient focus did not mean that the 'other things' were not considered or addressed. These 'other things' to do with establishing cause or ways of preventing further harm for the patient were important, but in the moment what prevailed was an instinctive need to concentrate on providing compassionate care. The patient focus provided a sense of safety, giving the team

permission as it were to place their energies into caring for the person in the given moment, even if it meant having to let go of their ‘egos’, traditional roles or desire to find answers. When the focus on, and compassionate care of, the patient is what matters most for the person doing the caring, it shows itself as solicitude. This concern for the patient subsequently guided the care and the associated interactions with the team, enabling them to work well together.

Heidegger described the mode of being-in-the-world as one of ‘concern’. Dasein in its very being is “for the sake of others” (Heidegger, 1927/1962, p.160), it is the way of Being-with. It is the essence of Dasein’s being-with others in the world that is “made visible as *care*” (Heidegger, 1927/1962, p. 83). The motivation to care-for others comes from Dasein’s Being and shows itself as solicitude. Solicitude is a state of Dasein’s Being and is how Dasein relates to others in the world.

In Paula’s account of good interprofessional teamwork, the patient is central. In putting the patient in the centre, the team reveal concerned solicitude. Coming together for and with the patient provided the platform for the provision of high quality care.

I guess the key things for me to ensure positive outcomes for the patients are good team communication, clear goals, and being respectful of the different clinical points of view. We all want the same thing for the patient but we’re all coming with different hats on, we see things differently because of the information we have about that person. It’s only the wrapping around of all those different disciplines that can bring about really truly positive outcomes. It’s like the elite service isn’t it? The patient can’t go home if those people aren’t talking to each other and the patient can’t get better if those people aren’t all working together. We have to all be working together as a team, with the patient in the centre of it. When the team is functioning well you get a lot of good work done for the patient and you can see really positive outcomes.

The mode of being-with others, within the team Paula describes, is one where they act out of solicitude. Where what matters most is the patient. When concern is focussed on the patient, it changes how the team work, drawing them together in a unity of purpose; wrapping them around the person. They are open to possibilities and other points of view.

Paula describes a team working in unison, a team with a shared focus and vision that brings and keeps them working together. She draws attention to the fact that each member of the healthcare team has different knowledge, skills and perspectives, and when good communication and respect for one another exist, the ‘wrapping’ of the different team members around the patient is possible, enabling them to receive the benefit of multiple

points of view; the ‘elite service’. Patient/family centred focus to care remains a prominent feature in participants’ accounts of working with others.

The Spirit of Interprofessional Practice as Relational

The helping professions are in disarray... and disarray, as we know, means loss of identity and mutual respect – the very basis of effective working relationships. After all, you and I must know who we are, and who others are (and in respecting them, lose none of our own self respect) before we can work together effectively. (Lindenfield, 1968, p. 4)

Interprofessional practice is socially situated and relational (Radomski & Beckett, 2011), and as such the ‘doing with others’ in the real world of healthcare practice is messy and often problematic. Just how an interprofessional practice will evolve, and the complexities and interactions which spring from it cannot always be planned in advance.

Collaborative patient centred practice has been described by Herbert (2005b) as a practice orientation or ‘way’ of working together with patients. Over 60 years ago Mathewson (1955) described the way of working in the relational context of interprofessional practice, as one where narrow professional interests are outweighed by a sense of team spirit. In such situations there is a focus on human relations as opposed to purely administrative tasks, where team spirit invokes a spirit of interprofessional sharing, which results in a lack of desire to control the process, be professionally defensive or competitive. There is both personal and professional maturity, enabling those in the team to engage in dialogue and expand their horizons of understanding. There is a fluency in interprofessional relations, a practiced ease; being able to find the ‘way’. Being able to work in a spirit of interprofessional practice is aided when those involved have a focus on others, on the human relationships, on the getting to know others, both personally and professionally.

Knowing others as people

The participants’ stories about knowing each other as people reveal both the drivers for practice and impact on the person.

Ricardo makes a conscious effort to get to know his colleagues and starts by finding a shared interest or some common ground which opens up the dialogue; the breaking of the ice.

I suppose with any other relationship with new people it’s kind of always finding some common ground to build on. I endeavour that when there’s a new colleague, I just be more friendly and have that relationship so at the end of it, when there’s a nice working relationship it makes working a lot more fun, a lot easier and you

burn out less. We have a new social worker who's Japanese actually. I found that one of the nurses would make comments to me asking if she is friendly, because they notice she doesn't really talk to people, she just goes there and talks with the patients and then leaves the nursing station. In fact that's a different perception to me. I find her quite warm, I find her quite accommodating.... For me, she's always just an email away and I can always collaborate. I think it's because for me I learnt a little Japanese so when I first met her I said 'Oh hey Konichiwa, blah, blah, blah!' So there was already that sense of 'Hey we have something in common.' So for me it's not necessarily because she's a social worker and I'm a nurse, it's more like 'who is she as a person' that I can relate with, and that breaks down the barrier, not necessarily the discipline.

Ricardo sees the barriers that exist between professions and the roles they undertake. He is not daunted by this and shows a determination to move beyond these historical and entrenched role barriers. He does not let difference interfere with building a relationship in order to create a favourable work environment in which to provide the best care for the patient. He sees beyond the professional role to the person. Breaking down professional barriers through getting to know others as people, finding some common ground, is a deliberate strategy Ricardo employs in the workplace. He sees this as integral to working as part of a team which ultimately makes his job easier and more enjoyable. It is his way of building and sustaining interprofessional relations in his practice context; it is his way of building team spirit. Ricardo gives another example of the value he places on getting to know members of the team, which has obvious benefits for the client.

I suppose working with other health professionals, the 'professional' doesn't come to me at the forefront, it's more like, where they have come from in terms of their ethnic backgrounds, regardless of whether they're a nurse, OT or physio. I think if I have a common interest I can relate to them in a more personal way that is not perhaps exactly like in a 'health professional manner,' it's easier for me to work with them. I think just get to know who they are as a person outside of work and then I find a similar interest. For example I was working with a new house officer, he's quite friendly actually, he's Pakeha, he's white but I think we share the same sense of humour and we have quite a good relationship. He plays basketball as well so I said 'Oh hey, so maybe we can do something,' yeah so we did. There's just some instances you talk to people and you feel like you just click and in this relationship with him, I get more done in terms of 'Oh hey can you please change the medication for this person,' and it just happens very quickly, because you have that relationship to work from.

Ricardo demonstrates a commitment to fully engage with others where he shows a comportment to openness. He describes how he approaches relationship development, where he actively engages a person, working to open up a dialogue in order to find some

common ground between them. Ricardo appears to ignore hidden traditional hierarchical ‘rules’ which work to constrain who he ‘can or can’t’ and ‘should or shouldn’t’ talk to. He does not let hierarchy stand in the way of getting to know the other person. He wants to form his own opinion and try and establish a good working relationship which he sees comes from first developing a personal relationship. Having that personal connection, seeing the person as more than a nurse, OT or physio makes Ricardo’s job easier, more enjoyable, where he is able to let his guard down and not have to be ‘professional’ every minute of the day. Without that connection it may be difficult to move beyond seeing the person within their professional role, hindering the level of openness and confidence to approach them. Having that connection contributes to a more productive working relationship in terms of allowing him to get things done; things that may not have been resolved so quickly or even at all, had he not had this relationship. Informality and relating on a personal level seem to be important here. Ricardo’s experience suggests that entering into a relationship with openness supports the development of a connection, which in turn expedites work tasks enabling him to meet the needs of his patients.

Ricardo’s experiences of getting to know others as people first, provided a platform from which to get to know them professionally and to build a relationship. Other participant examples also highlight the importance of knowing others, and knowing others’ roles and contributions as health practitioners.

Knowing others as health practitioners

Spending time with others, learning about them, their professional roles, scope and contribution can ultimately contribute to the patients’ care. Thomas recollected such an interprofessional experience with an orthopaedic surgeon. Without the surgeon in this case having known Thomas’ role and capabilities, his contribution in terms of the patient may have been lost.

Ironically, I’ve had some of the best experiences of interprofessional practice with orthopaedic surgeons. I think it’s the person and the values that they place in other professions. One that I worked with in the UK, I remember being blown away standing in front of a whole grand round when the surgeon said, ‘I don’t know, Thomas what do you reckon we should do for this person?’ We had worked closely together for about a year by that stage and he knew I spent a lot more time with the patients so knew I’d already tried to relocate his shoulder that day. We’d already had a couple of goes at these things so he knew I was probably the best person to answer the question at that time anyway. If people can step outside their ego, step outside the perceived role that they have to lead or whatever, and

go 'I'm comfortable in my skin, what do you think we should do?' Then the relationship's easy.

In the spending time together and getting to know each other, came a valuing of each other's contribution. This knowing each other brought a feeling of ease; there was a sense that it was okay to let go, to open up and seek the support of others. This was aided by what Thomas describes as an ability to 'feel comfortable in your own skin'. Being comfortable and having a level of confidence, along with a focus on providing the best care for the patient, opens the way for genuine dialogue, allowing the opportunity for others to lead. Thomas was, in this case, best placed to contribute to the care planning for the patient. The relationship expanded their horizon of understanding and shifted how they chose to communicate; it opened up possibilities.

Amanda also describes the importance of knowing other team members when working in emergency situations and, as above, what is seen is a shift in the way the team communicate. There is much that does not need to be said, but a knowing that the important things will be achieved collectively.

What made the team work well were the people and the relationships within the team. There were people in the team who knew each other. In the knowing of other's strengths and weaknesses, there is an ease about how things will work. You know they have the skills to do the job in that situation and you don't need to think about it or check up on them or worry about them feeling out of depth and not being able to tell you, and they also know what information you need to know about what they are doing. It enables some trust, it creates an ease and sense of relative calm. I think that it makes a real difference in terms of feelings of comfort. I don't think it's essential. I think you can have a team that works really well without that. But I think it takes more work in terms of communication. When you know somebody there are things that don't need to be said. With people who I didn't know so well, the communication was more explicit rather than implicit. When it is there, it's great. I think it does make a difference, but the reality is that it's not going to be there all the time or maybe even not most of the time. There are ways and means of creating that trust and that openness without necessarily having that history, but I think the history makes it easier.

In Amanda's experience, knowing others in the team facilitated a sense of trust and this trust allowed her to focus on the job at hand without being unnecessarily concerned about what others were doing. There was an already-there understanding that came from the establishment of a trusting relationship. The knowing of others felt comfortable, it made her job easier, it brought a sense of calm to the situation, it did not require as much effort because there was an unspoken understanding, a familiarity with how the other person

works. Knowing others in the team, having a relationship, made working together easier. Working collaboratively of course can happen when team members do not know each other well, but the trustful knowing adds another dimension to the relationship which Amanda describes as contributing to her sense of comfort and ease. Her experience is that more explicit communication is required where ‘knowing each other’ is not there and teams have not yet developed trusting relationships.

The Spirit of Interprofessional Practice as Trust and Trustworthiness

Mutual respect and trust are fundamental to relationships. They provide the essential conditions for good interpersonal relationships, where no one feels threatened; however, trust is something which is all too often taken for granted (Mathewson, 1955; Penglase, 2014). Trust is made up of three parts: it involves a truster, a trustee and the thing which the trustee is entrusted (McCraw, 2015). Trusting relationships rely on the trustee being trustworthy, which can place the truster in a vulnerable position (Dinc & Gastmans, 2012). The following characteristics of trustworthiness have been drawn from the literature and include: generosity, charity, compassion, discretion, patience, honesty, reliability, compliance, respect, fidelity, confidence, expectation, competence and belief (Dinc & Gastmans, 2012; McCraw, 2015). When these characteristics are present and trust is considered high, things get done better and faster; people are more engaged and find meaning in their work; they are happier, less stressed, less absent; and open to the exchange and sharing of information, which in turn improves productivity (Penglase, 2014). Despite the acknowledgement of its characteristics and positive outcomes, there is a lack of an agreed definition of trust amongst researchers (Dinc & Gastmans, 2012).

Trust appears to be as important in the patient-practitioner relationship, as it is in the practitioner-practitioner relationship. In this next story, Amanda reflects on her vulnerability and the consequences when those she had placed her trust in were no longer trustworthy in her eyes.

There's no doubt that for most people, it's easiest to do your best and be your best and see the most broadly, when you feel safe to be appreciated and valued. There have certainly been lots of situations as a student and as a younger doctor where I have felt belittled. I think that it does a couple of things. It makes me lose focus, it becomes a lot more about me and what I have done wrong or how I could have done better. Whereas when I'm feeling the other things, it doesn't have to be about me at all because then I can just focus on the patient really. When I'm focussed on me for whatever reason it's easier to make mistakes or not pick up on things or my focus narrows. My attention narrows. I'm not able to think of other possibilities or have a broader perspective in terms of diagnosis or other

things going on.... I think that it really cramps down self-reflection and being able to look broader.... When I feel trusted, whether it's a patient trusting me to do the best for them or a team trusting me to lead them, or being trusted to deal with a difficult patient, it's this trust that enables me to do my job well. It enables me to be more expansive, more creative in thinking of other alternatives, more decisive, more confident in myself to make decisions and go with that but still be open to other possibilities. It also enables me to let go of my ego a little bit and just do what needs to be done.

For Amanda, she was able to do and be her best when she felt safe; when she was able to trust in others and when others trusted her. It was at these times where she was at her most creative, her most confident, focussed; her best. Trust enabled her to expand her horizon of understanding, it allowed her to be open to other ways of being and doing in her work environment. It enabled her to pay attention to the things that mattered most, the patient. When she did not feel trusted or able to trust others, her focus shifted from the patient to herself, it narrowed her perspective, impacting on the quality of care she provided. When trust is absent the vulnerability of interprofessional relationships and the limiting effect it can have on healthcare practice are revealed.

Amanda goes on further to describe a situation when trust was breached.

I can think of a situation where that trust was breached. A couple of years ago there was a situation in our department where they were thinking about changing models of care, and for a number of people in my position, our jobs were at risk. The way that all came about absolutely meant that there was a breach of our trust with management. It felt horrible and it's very difficult to then focus on your job because you're busy being angry or wondering why or you kind of then distrust almost everything. Trust is such an important thing because if it's breached in one area it's really hard to keep it in just that area because it just encompasses everything.

The all-encompassing impact of a breach of trust on Amanda was disturbing. It was not something she was able to compartmentalise and its negative impact stretched to encompass many aspects of her work life. It became hard for Amanda to do a good job. The trust she once held and the trust she had assumed others had in her had gone. It meant uncertainty, vulnerability, and a questioning of her value and role within the organisation. It resulted in a generalised distrust affecting her ability to cultivate trustworthy relationships. It diminished her capacity to trust others, and a more pervasive attitude of distrust ensued to the point where it affected her ability to focus on her job; she was unable to enact interprofessional trust.

Trust fosters confidence and sense of togetherness

Jenny identified the healthcare team as key to ensuring a positive outcome for the patient. Successful interprofessional teamwork requires the development of relationships based on trust and respect.

Another key factor for the success of the interdisciplinary team I worked in was ... being able to trust other professionals. It means that you can let go of some bits of what you're doing and acquire others, because it's all about the client outcome and you know it will work out in the end. You do establish that trust, you get good at working alongside other professionals, but I think trust relationships take time to develop and develop faster with more experienced team members. Like, in the acute setting, you get good at looking across the bed, making eye contact, 'I'm terrified, what are we going to do?' You don't say anything, you just look at your colleague and you get good at recognising these facial expressions and understanding where you're going and you intervene on behalf of each other.

Having a good relationship with other members of the team is seen by Jenny as necessary in the provision of good care resulting in positive outcomes for the patient. Jenny recognised that in order to build an effective relationship that would benefit the patient, she needed to trust others. Trusting in those she was working with and trusting that they too had a focus on the patient meant that professional role boundaries became a secondary consideration, not at the forefront, but were flexible depending on what was best for the client. The trust fostered a sense of togetherness which opened them up to each other and to other possibilities. It fostered a sense of safety which reassured Jenny that things would work out in the end. When trust is present, it feels safe, it frees people up to be the best they can be, to provide the best care they can. It opens the way to focus on what matters most, the patient.

In this trusting comes a knowing, and in the knowing, there comes an ease, and unspoken understanding. An unspoken moment of shared understanding; a look, a recognition, an understanding that brings people together. A moment shared; a sense of togetherness, a sense that it will be okay because we are in this together. Such moments come when trust is present; moments that are taken for granted.

Role of respect and trust in promoting an open relationship

Without trust and the respect that is implicit in trust, developing and maintaining positive relationships is compromised. Jenny describes the role relationships play in facilitating and hindering interprofessional practice.

When I worked as an outpatient physio we did a lot of vestibular rehabilitation and worked with both neurologists and ENT [Ear, Nose and Throat] consultants. Interestingly, they're just completely different relationships. With the ENT consultant we would email them directly, write letters to them directly, we would be able to say 'I've done this, what do you think?' We had a process whereby they would refer a patient with vertigo or dizziness to us first and if we couldn't help we would send them back. So probably 80% of the people they referred to us, they never saw because we would address the issue and discharge them. By contrast the neurologists would send a referral and ask that we advise them on the issue. If we needed to ring the neurologists for something urgent, they didn't really like being rung and would be a little bit disappointed that we had wasted their time! They tended to be disregarding and if we made a suggestion they would say they'd take it into consideration. They weren't as engaging, not as open. As a consequence, we didn't engage with them as much as the ENT consultants and if there was the option to send the person to ENT instead of neurology, we would do that. We made much better use of the ENT consultants which meant the patients felt more part of the process... There was a very different level of trust and respect between the two groups and because of this we would avoid having to deal with the neurologists as much as we could.

Feeling respected and trusted, and being able to trust others, significantly influenced how Jenny provided care for her patients. In this example, Jenny is gravitating toward the profession that engaged with her, that recognised and valued her contribution, that showed her respect, that shared her vision, and treated her as an equal. She was able to put her trust in others and in turn, they trusted her to be able to do her job. A trusting relationship was built on this mutual respect and understanding. Feeling valued and being treated respectfully opened the way for dialogue between the disciplines. There was an inclination and openness to engage in genuine dialogue. This genuine dialogue enabled the development of mutual working arrangements such as clear referral processes and direct communication channels and opened the way for further dialogue and the too-ing and fro-ing necessary when working to address complex clinical issues. For Gadamer (1975/2013), a prerequisite for engaging in genuine dialogue is being on a level playing field which involves being open to, valuing and respecting the contribution of others. The ENT consultants showed openness to the contribution of the physiotherapist. They showed through their actions the value they placed in the other's contribution and their

interactions were respectful. They demonstrated trustworthiness, which opened the way for trust to be built and in turn facilitated the development of productive ways of working, relating and caring.

The relationship between physiotherapy and the neurologists, however, signalled a less productive relationship. Jenny describes feeling distanced and disregarded. Respect was not visible. There was no platform for the development of trust. This resulted in a lack of engagement and avoidance from Jenny, which directly impacted on patient care. It stifled the option to engage in dialogue, to develop new and improved ways of working, to put the patient at the centre. Collaborative patient centred practice was hampered by a lack of trust and respect, which in this case characterised its failure.

From this narrative it can be seen that the trust and respect implicit in the relationship directly influenced the quality of outcomes for the patient.

The Spirit of Interprofessional Practice as the Comportment of Openness

In human relations the important thing is, as we have seen, to experience the Thou truly as a Thou – ie., not to overlook his claim but to let him really say something to us. Here is where openness belongs. But ultimately this openness does not exist only for the person who speaks; rather, anyone who listens is fundamentally open. Without such openness to one another there is no genuine bond. (Gadamer, 1975/2013, p. 369)

Working in the spirit of interprofessional practice requires willingness, active engagement through listening, asking questions, making an effort, risking and revising prejudices until understanding is reached (Vilhauer, 2013). It involves being open to others, to trying new things, to the merging of roles, to the letting go or freeing up. Somewhere there are boundaries but there is an openness around the edges. There is a ‘play’ in openness, where there is openness to some things and not others. Comportment of openness is characterised by listening with care, being sensitive to others, taking the claims of others seriously, not being a spoilsport and being ready to be challenged and transformed (Gadamer, 1975/2013; Vilhauer, 2013). Openness involves keeping the dialectic going. Having comportment of openness is necessary for understanding. “It is the comportment of openness that leads us... to move beyond the near-sightedness of our own individual perspectives and towards more universal points of view with regards to the subject matter” (Vilhauer, 2013, p. 77). Being open and comporting oneself with openness in interprofessional encounters allows a shift in focus from oneself to the patient and others involved in caring for the patient.

The following stories show this openness in play in interprofessional encounters.

Openness to the unique contribution of others

One of the strengths of interprofessional practice, from Amanda's perspective, is the bringing together of different disciplines' skills, abilities and perspectives to contribute to developing a comprehensive picture of the person and a robust care plan. Amanda, a doctor working in an accident and emergency department of an inner city hospital, describes a context where retaining these distinct roles contributes to the care of the person.

Management or government might say 'Well okay if a nurse can do that fantastic they can come and do this and this and this.' There's no doubt there's some cross over, but there's also a lot of what we each do, that is not always easy to describe or prescribe that's not so easy to cross over. We doctors do tend to work from a biomedical model particularly for some of those kinds of things that the nurse practitioners also do, with orthopaedics, fractures and wounds and you start thinking about the person with the broken arm or the dislocated elbow. Whereas if we're all kind of thinking about that, then who's thinking about the care of the patient and how they're going to manage at home. There's a lot of compassionate person skills that come with nursing and learning to nurse that we don't necessarily have or get in medicine, there's no doubt there's crossover but that role of being the patient advocate and seeing the patient from that point of view is a really important one that you don't want to lose. A lot of those nursing skills that are difficult to name or difficult to count but are really incredibly important for the patient and their experience and their outcomes, I think that some of those kinds of things are at risk of being lost if things change too much. I think that just homogenising everybody is the wrong thing to do.

Amanda is not suggesting that role blurring does not exist or indeed that it is not helpful. What she does highlight is that we each come into the care of a patient with a unique way of viewing and relating to the patient. These unique perspectives enhance the care received by the patient, but often remain hidden in the everyday doing of practice. These ways of being within a healthcare discipline just 'are'. The unique attributes can be difficult to quantify, but are often the things which set the different disciplines apart. Amanda does not want to see *homogenised* health professionals; it is important to retain the unique traits each brings to an encounter and how this is done appears to be what is important here; with openness.

Openness to the sharing of roles

Jenny, a physiotherapist, describes working in a team where there was a clear focus on a team approach to care. The unique contributions of the disciplines were captured and used in the planning stages of care, but the person best placed to provide care was put

forward as the main care provider. The focus was not on individual health professionals and their specific skill set. There was an openness to the letting go of traditional professional role expectations and a merging of roles and responsibilities. There was an openness to this way of working and a sense that it would better facilitate the person's recovery.

I worked in a team with experienced practitioners from different disciplines. It was a brain injury rehabilitation team that was led by a psychologist and was, I would say, truly interdisciplinary. It was also a very admired team that people wanted to be in. We'd come together and talk about what the person needed and who within that team was going to deliver that. I often used to take clients up to one of the community gyms, which involved taking these individuals on the bus. They would have to manage their money, get on the bus, deal with social interaction on the bus and then we'd go up to the gym and they'd do their exercise programme and then we'd head back again. I'd facilitate this in a graduated way to promote their independence with that activity. It took me a couple of months to realise that I wasn't really acting as a physio, or what I perceived was a physio. The activity was actually occupation because they generally had physical function and I was facilitating them doing something meaningful with their lives as they recovered from brain injury. And whilst they may have perceived that it was physiotherapy and initially I perceived it that way, it actually was probably a lot more like occupational therapy, but did it matter? No, it did not. I realised that what we were actually doing was setting the individual up for success in life post brain injury and if we managed to keep him in his community independently, then what a fantastic outcome!

Team members contributed to the patient's care by way of involvement in the care planning process, which did not in this case translate into each discipline actually 'doing' the treatment. The doing was delegated. Jenny realised after some time that the role she was fulfilling looked like the role of another discipline. In fact she describes what she had been doing as occupational therapy, not physiotherapy. She had come into a team that worked in an interprofessional way and had been unreservedly carrying out her role as determined and supported by the team. At this point, she gave it no thought. It was expected. She could see its value for the patient. The outcomes spoke for themselves. She showed an openness to step outside what she had previously perceived as her role.

In this case and in this context, Jenny was identified as the person best placed to work with the patient. She took on roles that were unlikely to have been in her job description, but where the lines were blurred between professions. There is 'movement' or 'play' around the edges of professional roles. Role blurring is a reality of practice and in Jenny's case an expectation for the provision of effective care in this context. She was given

‘permission’ to work in this way, which validated her practice and gave her a sense of confidence. This way of working initially challenged Jenny’s sense of professional identity and required adjustment. It would not have been in the patient’s best interest to have all members of the team carrying out discrete parts of the care plan. This would likely have resulted in fragmentation, a lack of fluidity, confusion, and multiple inefficiencies. This approach was considered in the best interests of the patient, and the organisation. Their patient focus and openness to move beyond traditional or siloed professional practices, or a multidisciplinary way of working, enabled them to take an interprofessional approach to care.

Role blurring in this context was a conscious choice; it was seen as a necessity, a positive consequence of patient centred practice. There was an openness to a different way of working that set it apart from other health care environments. With the firm focus on the needs of the patient, came an openness to work in a way that best enabled the patients’ needs to be met. Such an example reveals an openness to let go, to take on, to do whatever was going to benefit the patient.

Amanda describes another encounter in which the roles prescribed to team members were not profession-determined, but were explicitly based on the needs of the patient within this context.

In this resuscitation team situation we knew the patient was on their way in so there was a little bit of time to prepare and clearly set roles. In a resuscitation there are fairly defined roles so somebody will be on the defibrillator, somebody doing compressions, somebody looking after the airway etc. Although the roles are fairly set, they merge and they definitely need to move around, particularly the person doing the compressions because you can only do it for a couple of minutes. There was an ease in terms of these roles.

As with Jenny’s story above, the team came together to prepare for the patient and develop a shared plan. There was time for the team to plan. During this preparation time, team members were clear on what needed to be done and roles were allocated. They were not necessarily allocated based on the person’s profession, they were roles that anyone in the team could do. There was a focus on what needed to be done for this patient, at this time, within this context.

Amanda describes an ease that came with the way in which people fulfilled and/or changed their roles. There are a number of possibilities in play when considering what may lie behind the ease with which this team worked, including: the time that was allocated to discuss, plan and allocate roles and the dialogue and role clarity that resulted;

an openness to fulfilling whatever role was allocated, to move beyond and to let go; the fact that this was an expected, accepted and implicit way of working in this context; and the clear team focus on the patient. There is recognition that in this context it worked.

What is important here is having different health professionals' contribution in the care planning process. It is about practitioners being involved in the care, but not necessarily having to take on traditional discipline specific roles. This shows an openness to different ways of working driven by the patient's, not the profession's requirements.

Openness as opening one's mind to the possibilities

Carey talks about how opening her mind to other professions and a different way of working both enabled effective and targeted care for the patient, and increased her confidence and sense of connection to the team.

Physiotherapy is such a tangible profession where you do things with people, you get them riding the bike and you get them in the gym and you see results. Whereas you see other professions trotting people off to their departments and you're like "what have they done?" It's not as tangible but of course those things, when you understand those professions and the types of interventions they do, you know that the things they are doing are equally as valuable. Being able to understand and acknowledge what goes on in those sessions is important. As I worked more with the psychologist and began to understand more about that profession, I came to realise that although what some other professions do are not as tangible as physiotherapy, they are of equal value. This experience [of working with the psychologist] opened my mind to the fact that working in this way was not about letting anything go, but rather opening up my mind to the possibilities and roles of other disciplines and how this can help the patient. As well as opening my thinking it gave me additional confidence, I felt more connected and part of the team. It felt good. We talked a lot more, went into each other's offices, we celebrated our success together and really got to grips with the needs of the patients we worked with. Working in this way not only allowed us to better understand his needs, we were also able to deliver care which was more efficient and effective for him, care that was more targeted, not like a scattergun approach. The best feedback you can get from a patient that you have worked with is that they want to stay connected.

Carey showed an openness to the possibilities of a different way of working, a different way of viewing the patient. Openness and broadening her knowledge of others came from the actual experience of working together, enabling Carey to see the value of drawing on each other's strengths. Being open to others and having a focus on the patient opened the way for collaborative practice. Working collaboratively meant the team were

better able to meet the patient's needs, and Carey felt more confident and connected to the team which generated further collaborative practice.

For Gadamer (1975/2013) there are experiences that meet and confirm our expectations and then there are new experiences. Working in this way was new for Carey and it was through the experience that she acquired awareness and greater understanding of the psychologist's role. "If a new experience of an object occurs to us, this means that hitherto we have not seen the thing correctly and now know it better" (Gadamer, p. 362). Experience that challenges or changes our understandings is called dialectical; and the dialectical nature of Carey's experience opened her mind, enabling her to acquire a new horizon (Gadamer, 1975/2013). Through the experience of working with the psychologist she was able to 'see' what it was that the psychologist actually did and acquired a new respect, understanding and appreciation of the role of others. She spoke initially about not seeing the value in what others do. This changed only when she opened herself up to learning and working with other professions. What is sensed from Carey's narrative is that being open to the possibilities for the patient remained at the heart of her practice.

The Spirit of Interprofessional Practice as the Play of Dialogue

For genuine dialogue to occur there is a need for reciprocal openness, a shared commitment, for others to be treated as equals, and a shared comportment towards one another (Gadamer, 1975/2013). For Gadamer the notion of 'Play', the too-ing and fro-ing movement in dialogue, is key to understanding how we might approach the other in order for transformative dialogue to occur (Gadamer, 1975/2013; Vilhauer, 2013). Transformative dialogue is one where those engaged in the communication obtain a shared grasp of the issues at hand.

Dialogue as understanding

Carey, a physiotherapist, recalls one particular patient with a significant traumatic brain injury. In the beginning it felt like his treatment would be hard work. He was from another culture, incontinent, could not move and could not talk. Carey looked back with pride at the transformation in both the body and spirit of this man. *'By the end of his rehabilitation he was this strong Samoan guy who kept coming back to see us for months after he'd been discharged to get extra homework and exercises'*. At the same time she sees that it was a team effort that led to his successful treatment. *'In particular we worked together on improving his concentration and attention through a guided exercise*

programme'. To face his rehabilitation solely from the physiotherapy perspective was perhaps daunting but a team approach brought other strengths. While she could see where her own physiotherapy skills were needed she also came to see how, in themselves, they were not sufficient. She developed deep respect for how the psychologist impacted care, and enthusiastically followed her guidance in incorporating concentration exercises into her own treatment. The team used each other; they recognised problems and solved them together. The treatment programme was so much more than a uni-disciplinary approach. It was all about transforming one man back to being 'himself'.

He was one of those patients where it really made me realise what other professions do, where I fit in, where my profession fitted in for him. I think we did a really good job for this guy by all exploring each other's roles and almost crossing over what we did in delivering care for him. It was in working with this patient that I formed a close working relationship with the psychologist in particular. She was a dominant kind of person to be honest and physio by nature can also attract dominant sort of people into the profession. We started off almost jockeying for position in the schedule to do our own little bits and then we had some discussions and a bit of too-ing and fro-ing about each of our roles and we began to see that we could cross over and deliver each other's aspects, that's kind of how it played out. We both sort of began to put our guards down a little bit and opened up our thoughts about our professional roles. I was open to asking "what are you doing?" and "how is that going to work?" which led to the light bulb moment where we both recognised that we could work together and I could do this for her and she could do this for me and that's going to help the patient. It was actually seeing that our professions and interventions with this patient could cross over that prompted us to work together to identify his specific problems and use each other to deliver a combined treatment programme. The psychologist helped highlight that an exercise programme could address more than just the physical aspects, things like his current cognitive deficits. In particular we worked together on improving his concentration and attention through a guided exercise programme.

It was through engaging in dialogue that Carey describes a 'seeing' and 'opening up of' how things could be different. Gadamer (1975/2013) described dialogue as an inherently human mode of understanding which forces us to see things differently. This encounter allowed both parties to expand their own background understandings in order to reach a fuller understanding of the situation they found themselves in (Polkinghorne, 2000). Understanding, for Gadamer, is part of a dialogue. "He [Gadamer] showed that conversation holds possibilities to transform productively not only the understanding of the topic, but also the very being of the participants in the dialogue" (Lawn & Keane, 2011, p. 122). Understanding is more than just asserting one's own view in a dialogue.

It is about being transformed, where we are no longer as we were (Lavery, 2003). “*We both recognised that we could work together and I could do this for her and she could do this for me and that’s going to help the patient.*” The encounter was transformational in the sense that they learned something new, something which will alter how they continue to be in the future.

From the dialogue came recognition of a cross over in roles and their shared goals for the client, just with a different set of tools and perspectives. The dialogue revealed. They recognised that they could provide better care for this client if they worked together. It involved give and take, a listening attitude, negotiation, “*What are you doing?*” and “*How is that going to work?*” resulting in the development of activities which would both improve his concentration, and address his strengthening, coordination and balance needs all at the same time. They had not known what each other really did before they engaged in this dialogue. Without the conversation they may never have discovered the crossover or taken it to the next level of exploring how the blurring in roles could actually be used for the benefit of the client. Only by meeting in dialogue, which involves shared deliberation and which is based on mutual trust, can people respect each other as persons and reach mutual understanding. Such dialogue is seen as fundamental for the requirements of healthcare (Árnason, 2000).

Gadamer suggested that genuine dialogue emerges when we engage in conversations which we fall into, which are incomplete, lack structure and don’t follow any rules. The ‘play’ in dialogue happens without effort, “it happens as it were, by itself” (Gadamer, 1975/2013, p. 109). Carey illustrates the notion of ‘Play’ in dialogue when she talks about the too-ing and fro-ing in the conversation and how the building of understanding came from how the conversation ‘played out’. A topic may come to be more fully understood through the back and forward motion in dialogue and genuinely open conversations (Binding & Tapp, 2008). The play of the dialogue in Carey’s and the psychologist’s story just happened and, although it was purposeful, they could not predict how it would end. It appeared to absorb them both, allowing them to open up to one another.

Carey, the physiotherapist, and her team mate, the psychologist, both cautiously guarded their role in the care of this client, they ‘*jockeyed for position*’. However, they recognised that given the client’s complex and significant needs, neither profession could achieve what was necessary on their own. Professional boundaries faded in importance. The initiation of dialogic inquiry occurs when there is recognition that those involved lack the necessary knowledge or admit that they need to move beyond their own

understanding of a situation (Polkinghorne, 2000). This recognition prompted an openness to initiate and engage in dialogue. It was through engaging in conversation that they began to understand and work together. Gadamer asserted that conducting a dialogue requires all parties to be on the same page and not talk at cross purposes, “The first condition of the art of conversation is ensuring that the other person is with us” (Gadamer, 1975/2013, p. 375). Carey and the psychologist came to share an understanding.

For Heidegger (1927/1962) understanding comes from our being in the world, it is not worked out in the privacy of one’s mind. Dialogue is part of being in the world and shapes the way we understand the world and our practice (Gadamer, 1975/2013; Lawn & Keane, 2011). The too-ing and fro-ing of the dialogue enabled them to at some point feel safe enough to let their guards down. The dialogue enabled them to identify common ground that opened up a shared way forward in the care of the client. They were able to open their minds to the other profession and come up with a shared intervention plan. Carey says, *“We both sort of began to put our guards down a little bit and opened up our thoughts about our professional roles... that working in this way was not about letting anything go, but rather opening up my mind to the possibilities and roles of other disciplines and how this can help the patient.”*

Being open in dialogue

In this narrative Carey showed an ‘openness to self’ in dialogue where her level of self-knowledge enabled her to recognise her own prejudices as well as be open to new learning experiences and to practice in new and different ways (Árnason, 2000). She was aware that both her own profession and the psychologist’s, attract what she called “...a dominant kind of person.” This encounter brought to the fore her own limitations as a physiotherapist and may have prompted her to consider making contact with the psychologist. The high level of complexity and overwhelming nature of the client’s condition may have led them to seek each other out: *“He wasn’t at a stage when he was first admitted to express himself or in fact do very much for himself at all.”* Carey saw that her skills alone were not sufficient and other health professional input was required, or would be beneficial. She was willing to risk her own prior understandings, which Gadamer suggested is a prerequisite for authentic understanding; “Only those open to themselves will genuinely listen to other people” (Árnason, 2000, p. 20). Genuine engagement occurs when one is open to the possibility that something else might be the case (Sharkey, 2001), thus allowing new meanings to develop or be altered (Vilhauer,

2013). Having this ‘openness to oneself’ is described as a prerequisite for other forms of openness such as openness to others and the subject matter, or in this case, the patient (Árnason, 2000).

Carey was open to herself in that she was aware of her own potentially dominant nature. She was aware of the limitations of her role, she was open to acquiring new experiences and was eager to learn from these experiences in order to ensure the best possible care for her patient. This openness to herself facilitated an ‘openness to others’ when the situation called for it. It showed itself in her concern for the patient and the way she engaged in an open dialogue with her psychologist colleague. Carey demonstrates the art of the dialectic which is described by Gadamer (1975/2013) as “the art of conducting a real dialogue”, “the art of questioning and of seeking truth” (p. 375). The question and answer structure of real dialogue ensures that those involved do not talk at cross purposes. For dialogue to have fruitful and transformative outcomes there needs to be commitment and seriousness from all parties involved. This was evident in Carey’s story and the mutual engagement in dialogue enabled a re-examination of her own role and the role and contribution of the psychologist; broadening horizons. *“He was one of those patients where it really made me realise what other professions do, where I fit in, where my profession fitted in for him.”* Understanding according to Gadamer, is primarily about reaching an understanding with others (Binding & Tapp, 2008; Gadamer, 1975/2013). We cannot transcend our own horizon, but these new experiences gained in an open dialogue with the psychologist provided Carey the opportunity to re-evaluate and consider her position in relation to the Other (Lawn & Keane, 2011). Carey talks about ‘opening up their thoughts’, a ‘beginning to see’ and ‘recognition’ of how they might work together. This opening up and the mutual coming together of their understandings though dialogue, resulted in a light bulb moment, broadening of their horizons. For Gadamer, understanding is always the fusion of horizons and understanding is always part of a dialogue and is the accommodation of the Other (Gadamer, 1975/2013; Lawn & Keane, 2011). Dialogue which is a process of mutuality allows for the horizon of one to be brought into contact with the horizon of the Other (Lawn & Keane, 2011).

Being open to each other in this encounter involved pulling together their knowledge, describing and defending their perspectives, and appeared to have contributed to a stronger sense of their professional identities. The backwards and forward movement in dialogue led to a shared approach in the care of the patient, suggesting that they each respected the contribution of the other and were prepared to place a part of their role in

the hands of another. Carey describes having a greater understanding of where she fitted into the team after working with this patient. Working collaboratively and the sharing or blurring of their roles, did not appear to dilute her sense of professional self. Rather it appeared to have the opposite effect of strengthening her own sense of identity and her identity within the team.

The reaching of understanding comes from an understanding with others, but understanding is also always ‘with respect to something’ (Gadamer, 1975/2013). Being open to the Subject Matter, in this case a patient with complex needs, provides direction for both the Self and the Other. This focus lets them be led by the patient’s needs, and because of this will preclude the relationship from being dominated by their prejudices (Gadamer, 1975/2013). When the subject matter becomes the focal point of a conversation and those involved in the conversation are directed and absorbed by it, conversations work well (Sharkey, 2001). “The goal of all attempts to reach an understanding is agreement concerning the subject matter” (Gadamer, 1975/2013, p. 303). Those involved in genuine dialogue allow it to take over and lead the conversation – they become responsive and involved in the subject matter. Authentic conversation is where those involved surrender to the ebb and flow as the conversation unfolds, they are led by it and become involved and use the art of questioning (Gadamer, 1975/2013). Carey used questions to weigh and test what the other had to say, which opened up possibilities and insights. This facilitated the dialectical movement of the conversation and the formation of ideas toward a common meaning (Árnason, 2000; Gadamer, 1975/2013). The too-ing and fro-ing and the art of questioning as described by Carey demonstrates the dialectical movement toward finding a shared way forward in the care of this patient. The dialogue in which Carey and the psychologist engaged led to collaborative and creative approaches to care with a clear focus on the needs of the patient. Patient centeredness is at the heart of Carey’s openness and engagement in genuine dialogue – it is at the heart of interprofessional practice. Not all interprofessional interactions are about the patient directly, but this is the thing that health professionals have in common, that drives collaborative practice.

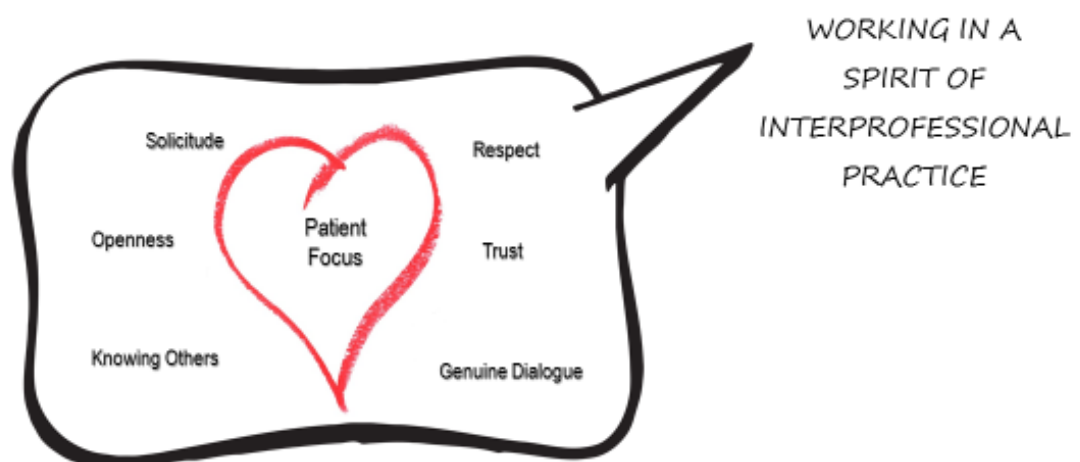
If there is an openness to the Self, the Other and the patient in dialogue, the horizons of those involved will broaden, opening the way for collaborative and creative practices. A fusion of horizons, a coming to understanding, the expanding of one’s worldview in relation to another’s has been shown in many of the participants’ stories above. This was real for Carey: *“It was actually seeing that our professions and interventions with this*

patient could cross over that prompted us to work together to identify his specific problems and use each other to deliver a combined treatment programme.” By taking the time to engage in dialogue, they could move beyond their silos and ‘see’ a different way, a better way. Effective interprofessional practice requires genuine dialogue which in turn requires that it is entered into with openness. Dialogue facilitates openness but openness also needs to be present in order to choose to engage in dialogue.

Toward the Spirit of Interprofessional Practice

The art of understanding is a circular relationship that comes from having an understanding of the whole in relation to the detail and the detail in relation to the whole, which is described as the hermeneutic circle (Gadamer, 1975/2013). The meaning of the spirit of interprofessional practice as a whole comes when there is an understanding of the things that contribute to this notion being what it is. The things which have been identified as meaningful for a spirit of interprofessional practice to ‘be’, have been drawn from stories of practice, each of which was situated within the participants’ and the researcher’s specific historical horizon. The hermeneutic circle involves an interpretive process in which one’s background understandings or horizon of understanding comes into play. With this in mind, as the researcher I have shone a light on a number of aspects which, when gathered together, work to enable practitioners to work in a spirit of interprofessional practice. See Figure 1 which brings together some of the aspects of working in a spirit of interprofessional practice that I have interpreted as mattering for the participants in this study.

Figure 1. Working in a Spirit of Interprofessional Practice: The Things that Matter



Interprofessional practice is a complex, relational phenomena. In interpreting the narratives from health professional experiences of working with others in practice, it is apparent that care of the patient is at its heart. At the very essence of Dasein's being-in-the-world is care. When what matters most is the patient; this concern shows itself as solicitude. It is this solicitude which shows itself as being at the heart of interprofessional practice. The spirit with which practitioners engaged with their colleagues was one where the patient remained at the forefront. A compassionate patient focus united the team, created a team spirit and guided their actions. It removed a focus on self, and promoted creativity and understanding. It contributed to the building of positive and mutually beneficial relationships and the mutual trust and respect implicit within them. Having positive working relationships contributed to practitioners' enjoyment, sense of accomplishment, confidence, making their jobs enjoyable, easier and more productive. Relationships were formed through getting to know others as people as well as health professionals. This enhanced relationships and a valuing of the other, provided a sense of ease and comfort in the thrownness of everyday practice. It facilitated trust. Trust was empowering. Being able to trust others and feeling trusted fostered patient centred care and meant that traditional disciplinary roles were not at the forefront. What was at the forefront was the patient.

Feeling valued and respected opened the way for genuine dialogue, together finding the best ways to care. The stories were about the letting go, the merging of roles, the openness to other ways of meeting the patient's needs. What mattered was being open to others' unique perspectives; not being unnecessarily concerned with who delivers what aspects of the care. The experience of working together and getting to know others brought new respect and understanding. With such a spirit at play, interprofessional practice was seen to thrive.

CHAPTER SEVEN

SAFEGUARDING AND PRESERVING THE SPIRIT OF INTERPROFESSIONAL PRACTICE

Introduction

The previous chapter revealed features necessary for successful interprofessional working; features which point to the heart of interprofessional practice and which allow those involved to work in a spirit of interprofessional practice. This chapter will draw on further stories to reveal contextual aspects that appear to matter in the safeguarding and preserving of successful interprofessional practice.

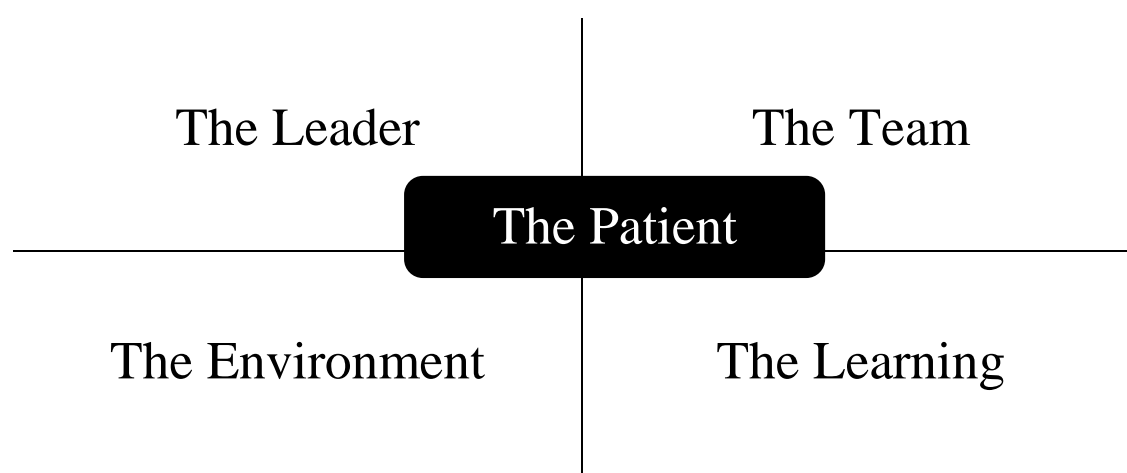
Interprofessional practice cannot be reduced to a single aspect, it is about everything. The things that call us, the spirit with which we engage in the phenomenon that is interprofessional practice and the things that safeguard and preserve interprofessional practice are all dependent on the other. Everything comes into play.

Examining the richness and complexity of interprofessional practice within specific contexts, enables a richer understanding of the fluidity, dynamic nature, and thrownness of clinical practice (Radomski & Beckett, 2011). Those things which call us to work collaboratively and those things which reveal themselves as important in the midst of the collaborating occur within a wider context. The context influences the level at which the spirit of interprofessional practice occurs and can be preserved. Studies have shown that even subtle changes in the context can influence behaviour, even more than static or stable individual personality traits (Sargeant, 2009). An interprofessional practice context, or the spaces where interprofessional practice take place, provides a reference point for certain ways of being-in-the-world, of acting, orienting and organising activities within the space (Heidegger, 1927/1962). Heidegger used the term ‘region’, which dictates a certain “referential organisation with respect to our context of activities” (Arisaka, 1996, p. 38). A region is a space where Dasein exists and acts in deliberate ways to achieve a specific purpose. Different regions require different responses because the region determines what and where things belong and how we use what is ready-to-hand.

Four key dimensions of interprofessional practice have been drawn from the stories; dimensions within which there is a richness, complexity and interrelationship, and where

the patient remains central. These dimensions include the organisational environment, the leader, the team and the learning. In the previous chapter, the patient lay at the heart of interprofessional practice providing the focus for positive interprofessional experiences and outcomes. When concern was focussed on the patient, it influenced how the team worked, drawing the members of the team together in a unity of purpose. The team caring for the patient, the leader leading the team, the learning implicit in such interactions and the organisational environment in which this occurs are mutually interdependent. These four components form an interconnected whole, see Figure 2. One cannot exist without the other, which Heidegger (1927/1962) referred to as *equiprimordiality*. Each of these four dimensions mirror one another; and when talking about one, the other three also come into play (Harman, 2009; Heidegger, 1993). Heidegger referred to the fourfold, which contains dimensions that are interdependent, and cannot be considered individually. Interprofessional practice is the thing that gathers the fourfold, allowing a space for these four dimensions to unfold, be free to ‘ripen’, to be what they are (Heidegger, 1993).

Figure 2. The Fourfold Dimensions for Interprofessional Practice



This chapter is informed by Heidegger’s notion of the fourfold to help uncover how in these regions of interprofessional practice, the ‘oneness’ of the four dimensions of the leader, the team, the learning and the organisational environment, can safeguard this ‘spirit’ of interprofessional practice. To open the dialogue, to dwell on how the dimensions can safeguard and preserve a spirit of interprofessional practice means “...simply to let this fourfold be what it is” (Harman, 2009, p. 292). Heidegger’s actual

fourfold dimensions of earth and sky, divinities and mortals will not be referred to directly. The key argument relates to the equiprimordiality of the fourfold dimension. Dwelling with the parts in this way, helps to understand the whole. When all of these dimensions are aligned and merge, the particular ‘being’ of working in a ‘spirit’ of interprofessional practice can be revealed.

An interprofessional practice region has the patient at its heart. It exists because of the patient. It would not matter how effective a leader was, the team culture or the resources and systems that were in place, if they do not have a focus on the patient, effective interprofessional care would be challenging. A leader influences the ‘being-ness’ of the team, its culture and the way in which the region is interpreted and supportive of collaborative practices. An open and self-aware leader frees the team up to ‘be’ (Souba, 2011). How the team make sense of and act within the interprofessional region is dependent on the environment in which they find themselves. If the environment does not support collaborative practices, it would not matter how patient centred or effective the leader or the team culture was, the team would likely find interprofessional practice challenging to enact. An interprofessional team culture requires institutional support by way of relevant structures, processes and funding models, as well as an openness to learning from, with, and about others in order to preserve it.

Dimensions such as leading, the team culture, an openness to learning from, with, and about one another, and the structures and processes in place within the organisational environment, exert a powerful influence over attempts to bring about interprofessional collaborative practice. This chapter will weave a sense of how these fourfold dimensions interrelate and fit into the telling of the participants’ stories. The manner in which I am presenting the fourfold might seem repetitious, but I am echoing the style of Heidegger (1993). The very nature of the fourfold is that each of the four dimensions are found within each other. Thus to only point to ‘one’ is to disregard the very nature of the fourfold. The repetition (shaded) serves the purpose of gathering and holding the four together as one, again and again. It is to keep the gathered fourfold at the heart of the discussion.

The Leader

Taking an ontological position in the exploration of ‘being’ a leader means to consider the person’s lived experience and the underlying foundations of the ‘being-ness’ of effective leading (Souba, 2011). What does it feel like or mean to be an effective interprofessional leader?

Listening and dwelling with the stories has brought to the fore notions of being a leader that seem to matter in the safeguarding and preserving of interprofessional practice. However, we cannot talk about the leader without also referring to the other fourfold dimensions. When we say leader, “we are already thinking of the other three along with it, but we give no thought to the simple oneness of the four” (Heidegger, 1993, p. 351). Without a leader open to learning from, with and about others and attuned to interprofessional practice, it would not matter how great the team was, how focussed on the client they were or how good the systems and structures in place were, working in a spirit of interprofessional practice would be challenging.

Leading as facilitation

Amanda, an accident and emergency doctor, shares her thoughts on being a leader in a resuscitation/emergency department context.

I think that leadership perhaps in this situation or probably in a lot of situations is more facilitation. The leader has quite a powerful role in setting a scene and enabling the team to do the best job they can, whatever that is. In terms of finding the right people for the right jobs, in terms of setting a scene that is safe and encouraging, to allow people to let you know when they're out of their depth or give you knowledge that maybe they're a little bit reticent about voicing. Traditionally the environment has not been enabling of these things, it's been very hierarchical and disciplined. You don't want to sound or look stupid in front of your colleagues, people you admire or people who might help you progress in your job. There's all sorts of reasons why people may or may not speak up, but the more we can enable people to, the more we will learn from each other and ultimately it's good for the patient.

To facilitate has been defined as to make something easier or less difficult, to assist the progress of a person (Fowler & Fowler, 1978/1989). To facilitate is to open the way. The enabling role of facilitation, the actual way of being of a facilitator, in this and other contexts, is what Amanda advocates leading or leadership is. The leader as facilitator is suggestive of Heidegger's notion of ‘*vorausspringen*’ or ‘leaping ahead’, where others are empowered to act on their own terms, opening up options for others by ensuring it is safe to do so (Heidegger, 1927/1962; Tomkins & Simpson, 2015). In order to facilitate others to work at their best, the environment has to be right. It has to be safe. A safe environment is one where those within it are protected from harm, not exposed to danger (Merriam Webster Dictionary, 2016). The meaning of being or feeling safe comes from how this is experienced by the person in that place (Heidegger, 1927/1962). In Amanda's experience, when a sense of safety is felt by those in the team, it provides a platform for

enabling people to work at their best; it allows them to open up, to contribute without fear of looking or being made to look stupid. This contribution fosters dialogue, which in turn develops understanding, broadens horizons, and impacts on patient care.

Caring leadership, Tomkins and Simpson (2015) would suggest, requires understanding (*verstehen*), attunement (*befindlichkeit*) and absorption (*verfallen*) (Heidegger, 1927/1962). Amanda reveals herself to be this kind of leader. A leader who understood the need to provide a safe environment from which people were able to work interprofessionally, a leader attuned to the importance of enabling others to be free to have a voice, to speak out without fear, and who was absorbed and immersed with others in the everydayness of being-in-the-world.

A good leader for Amanda is someone who understands; is attuned to and immersed in the context, and possesses such qualities as respect, openness, compassion and effective communication. Leaders with such qualities, Amanda signals, are leaders able to provide safe, encouraging and supportive environments for the team to 'be'. A leader with these qualities sets a benchmark for compassionate patient centred care and models behaviours necessary for interprofessional practice. Enabling someone to feel safe and confident to speak up, is a leadership quality that supports a richer and safer learning and working environment.

Tony, a social worker working in a leadership role in a mental health environment, shows an authenticity in facilitating his team to work at their best.

So I got into Community Alcohol and Drug Service [CADS] and then realised the training I'd done, sure was enough to have a qualification, but my job was as an alcohol and other drug counsellor and methadone case manager. Well, I felt like a fraud, how am I going to do this? It wasn't a social work position, it was a counselling position. So I said to my employer I need training in counselling. So I went and got a diploma in counselling. While I was doing that training, they needed a methadone supervisor and there was a whole change of how methadone was going to be delivered. So suddenly I found myself as a supervisor within the methadone service. What I've found is that I've ended up in positions where I'm slightly ahead of my training, so I've had to go back and get the training. I suppose to me, in order to do a job well, I need to have some sort of theory or knowledge around it. So I've always sought knowledge out. Which is what I believe everyone needs to do who comes into a position.

Tony recognised the limitations in his knowledge and actively sought to remedy this for himself. This was motivated in response to becoming a leader and his personal theory around the importance of having a sound understanding of the practice area in which he

would be taking a leadership role. A caring leader, from a Heideggerian view, is one that Tomkins and Simpson (2015) suggested requires “the ability to reflect on one’s own leadership habits” (p. 1024). Those able to ‘own’ their personal experiences, values, beliefs, thoughts and emotions and act in line with their true selves could be described as authentic leaders (Gardner, Avolio, Luthans, May, & Walumbwa, 2005). Authenticity is being one’s own self (Heidegger, 1927/1962; M. King, 2001), an owning of one’s personal experiences and acting in accordance (Gardner et al., 2005), “it is being and acting consistent with who you hold yourself out to be for others” (Souba, 2011, p. 5). From Tony’s personal experience, he believed that specific additional education inspired an inner confidence which prompted him to act in response to his beliefs. It also translated into how he chose to enable others in his team to become the best they could be.

One of the things I say to all my new graduates is you’ve got your nursing qualification, you’ve got social work qualification, you’ve got your OT qualification, you’ve got your discipline, what you need now is training in an intervention. I don’t care what the intervention is, but something that makes sense to you. They need to get the therapy model under their belt, because then they can be intentional in what they do. In their interaction with the client. I don’t care what it is, get one modality that you know inside out, that you’re trained in and then you can just hang everything else you’ve learned off that and it will make sense. I think they feel more confident about voicing an idea, especially when they can link it back to stuff they’ve learned. It’s like putting theory into practice. Like there’s one of the nurses went off and did the Child & Adolescent Mental Health [CAMH] paper and then she just became more confident. The team becomes more confident and the skill level increases and the quality of service, I think, improves.

Tony facilitated others to be the best they could be. The fostering of positive self-development in others reflects an aspect of authenticity, which is evident in Tony’s way of being a leader. He recognised and drew on the things that worked for him and actively encouraged others in his team to do the same. Tony shows a way of being that was absorbed in his ‘thrown being’ in the world, an understanding which was drawn from past experiences, a sense of what was needed for good care to happen in the future, and an attunement to himself and others in the world.

Leading with tact

Amanda reflects further on interprofessional leading.

The leader doesn't necessarily need to know all the answers; I think that even if they do, they're not necessarily going to be able to access all the answers in a stressful situation. I don't think it matters whether they're the most senior doctor there, or a nurse, as long as they have the skills to enable, and as a leader, there does need to be respect and trust of other people. The way a leader speaks, the kinds of questions they ask, they set the tone to enable other people to think and act compassionately.

What is shown in Amanda's experience and perspective of leadership, and appears to be important, are the leadership qualities that shape how the team works, not the discipline, background and status, or prior knowledge of the leader. Gadamer suggested that the power invested in a teacher/leader does not mean that they are necessarily good teachers/leaders, good leaders hold their own authority when they have the capacity to draw in those around them (Gadamer, 1975/2013; Lawn & Keane, 2011). What Amanda reveals as important in this practice context is a leader who notices, who is sensitive to what is happening around her and in how she acts. A leader's ability to act with tact creates the space where others feel able to speak up; they feel safe. The ability to set a certain scene is dependent on a tactful leader, a leader attuned and oriented to the other (van Manen, 1991). Tact shows itself when a person has a certain sensitivity or sensitiveness to a situation and how they ought to behave, and is "characterized by moral intuitiveness: a tactful person seems to sense what is the right thing to do" (van Manen, 1991, p. 521). Interprofessional practice situations, as with any social context, are too complex for a single theory or set of leadership principles. "It is in the nature of theoretical knowledge that no social scientific facts, no moral philosophy, no teaching method can tell a teacher what to do in particular circumstances" (van Manen, 1995, p. 42). Amanda notes the need for a leader to have skills in enabling others, which are often intuitive, unplanned, in the moment responses and manifest in the tone of their voice, the type of questions they pose, and their ability to sense when someone feels reticent about speaking up. This type of practical knowing, van Manen (1995) suggested, is not located primarily in the intellect but rather "the existential situation in which the person finds himself or herself" (p. 45).

Conditions which Smythe, Payne, Wilson, Paddy, and Heard (2014) suggested allow tact to flourish include time, energy and a spirit of care. Time to listen, to watch, to sense, and to act compassionately; energy to work things through and let others do the same; and to be cared about enough to be able to act with compassion. Having a strength of spirit to lead tactfully in an interprofessional context fosters tact, which strengthens and sustains interprofessional practice.

Jenny, a physiotherapist in a leadership role, describes how tactful leading, a thoughtful noticing in the management of staff within her team, fostered and supported interprofessional relations.

I worked quite closely with the OT section head and before we moved staff we talked about, 'How will that go?' 'How will this person and this person with their different learning styles, how will that fit together?' and with some people we would say 'Hmm let's not do that because they might not get anything done.' Or 'this one might be too dominant to work with that one,' so we can't always control the whole situation but we do think about the team fit and whether or not an existing team will be disrupted with a certain personality or whether it would add and sometimes we don't know and we just try.

Implicit practical knowledge, the practical tact of knowing what to do, is shared between these two leaders. Tact allowed for sensitive, intentional and thoughtful human interaction, which was for the sake of others. Tact showed itself in the knowing of themselves, in their team members, in the awareness of the dynamics at play, in the sensing of individuals' needs and the potential impact on others, driving their decisions and actions. Leading requires active judgement, judgement which "...relies on interpretation and metaphoric association, on ways of seeing and imaginatively understanding what is required in practical changing situations" (van Manen, 1995, p. 45). They showed a practical active knowing embodied within them and in the things that surrounded them, their phenomenological knowledge (van Manen, 1995). Phronesis or their practice wisdom was in play. They were required to act in the moment, to make a call. *'Sometimes we don't know, we just try'*. They didn't know what to do, but drew on each other, the mood that had been created and their practice wisdom in guiding their actions (Smythe & Norton, 2011).

Jenny and her OT colleague drew on their thoughtful noticing, their sense of what might be the right thing to do. They used their intuition and their attunement to each other and those around them, allowing them to make decisions and have the confidence to test things out, to give them a try. They cared enough about the service they were providing to consider the team dynamics and how to get the best out of the team. They made time to listen and discuss, to plan. They showed tact in their leading. In the 'doing-ness' of leading, Jenny and her colleague modelled interprofessional practice. They worked collaboratively, locating the person (their staff, the patients and the organisation) at the forefront of their thoughtful thinking and doing. They gathered the fourfold.

Leading as patient centred

Jenny recalls a time when she worked with a strong leader in a brain injury rehabilitation team; a leader with a clear sense of what was right for, and in, this context.

We had a strong leader who had a psychology background. She very clearly defined what interdisciplinary teamwork looked like and what was expected from those in the team. It was really effective because it met the needs of the person not the needs of the professionals and was a rewarding way of working. The psychologist obviously perceived that this way of working provided really effective rehabilitation which enabled the effective management of the complex needs presented by the patients. If everyone had stayed in their traditional discipline boxes, some things were likely to be missed. You know, once everyone's created all their boundaries, what if there's something really important that's left over, that isn't under someone's hat and who does that? What was so worthwhile in this team was that rather than saying, 'Do what you're most comfortable with and we'll just see what's left over,' we said 'What does this person need and who can do which part of it.'

What is evident from Jenny's experience is the positioning of the patient within the practice context and the pivotal role of the leader in creating an interprofessional model of care. The psychologist in this service gave the team permission to work in what might be considered a spirit of interprofessional practice. Where the patient was central, where the crossing of roles was accepted, it became the norm. The team's focus on ensuring the best outcomes for patients meant there was no room to dwell on professional inequalities or become preoccupied with individual professional contributions; instead, it led to the sharing of roles and a sense that the team functioned on a level playing field. What the patient needed was driven by the patient and the team approach, and was delivered by whoever was in a position to provide the necessary care. The role overlap that occurred strengthened the care provided for the patient, it did not diminish the recognised professional contribution of team members. Care was not compartmentalised, it was holistic, resulting in aspects of care less likely to be missed. The working culture was driven by the leader who had a clear image of the care model she believed would enhance the outcomes for the patients in this context. There is a sense that the working culture that was developed, created an environment which facilitated trust and respect amongst team members; where the letting go or taking on of roles that may have traditionally sat outside of a particular discipline was just 'business as usual'. Being part of this interprofessional team and the doing of interprofessional practice was done with what could be described as self-forgetful ease (van Manen, 2007). It was without effort. The team were able to absorb themselves in the patient and the care the person needed.

Similarly Jocelyn, a senior occupational therapy leader, shares her thoughts on how a patient centred and inclusive approach to leadership came into play in an inpatient assessment, treatment and rehabilitation team.

My sense from talking with colleagues as well is that the A, T, and R [Assessment, Treatment and Rehabilitation] consultants are much less hierarchical and much more understanding of the value of other disciplines, the role of OT and the value that OT brings to the patient journey. They have a much more inclusive approach and more of an understanding of assisting people to recover or to live with whatever [health condition] they have, they are much more person centred. They're in a rehabilitation frame of mind if you like. It's a slower journey and there is a dedicated team that is going to transition them from the inpatient to rehab or home. They had patients who stayed longer and they had very stable staffing. The team felt valued, that they belonged and I think they felt they were in some senses different and a bit special.

The context feels important here. There is a dedicated, co-located team and the patients remain in the environment for extended periods of time. The pace is slower and the team is guided by the shared understanding that the patient is central. There is a sense that this allowed the team to get to know one another, it created the space to build relationships with the patients and each other. With the knowing, comes an understanding of the role and value of others. With the valuing came a sense of belonging, which may have been reflected in the stable nature of the team. The leading in this team was a valuing of others; it was inclusive and driven by the needs of the patients. The culture established within this team was being actively preserved by those in the team.

When the house officers arrived on the ward they were consciously orientated to this way of working. The senior, long standing team members realised that the house officers would come in and behave in ways that they had been behaving on other wards and found that it didn't work here. That actually their role was to be able to communicate effectively with the whole team. So they were massaged, moved and sometimes given direct feedback: 'That is not the way that you discuss things with the allied health practitioners and the nurses on this ward.' 'We do not work like that!'

Those entering the team were consciously moulded to conform to the expected culture which was central to what it meant to 'be' a team member within this particular interprofessional practice region. There is a sense from Jocelyn's account that the leaders within the team felt responsible for preserving and safeguarding the interprofessional culture that existed. A safeguarding against those things which could undermine the culture; a culture which had been carefully nurtured and one that worked for the patient

and the team. Subtle and not so subtle ways of leading and being in this context were used in the preservation of the team culture.

An interprofessional practice culture appeared to flourish in situations where the leader acted with tact, where she enabled others to be the best they could be, created a safe environment and where there was a strong focus on the patient.

The Team

Listening and dwelling with the stories has brought forward aspects of team culture and of 'being' a team member that appear to matter in relation to what makes 'good' interprofessional practice. However, we cannot talk about the team without also referring to the other fourfold dimensions. Without an interprofessional team or a team open to learning from, with and about others, there would be no ability to make interprofessional care happen. It would not matter how great the leader was, how focussed on the patient any health professional was or how good the systems and structures in place were, without a team, or without a supportive team culture, working in a spirit of interprofessional practice would be challenging.

The team: The sharing of roles

The coming together, the way of working in the brain injury rehabilitation team where Jenny worked, was a culture where team based care involved the sharing of roles for the benefit of the client. It did not matter who took on the required roles, as long as the team were able to contribute to the patient's care by communicating and collaborating where necessary and sharing their perspectives, knowledge and skills. It gave 'permission' for the team to work in this way; it was a way of working that initially challenged Jenny's sense of professional identity, which required adjustment and support.

If everyone had stayed in their traditional discipline boxes, some things were likely to be missed. I had a moment of, 'oh my goodness if someone else looked at this, have I actually stepped too far outside what I should be doing' and do I need to be worried. But that only lasted for a moment and then I realised that what we were actually doing was setting the individual up for success in life post brain injury and if we managed to keep him in his community independently then what a fantastic outcome! What was so worthwhile in this team was that rather than saying, 'Do what you're most comfortable with and we'll just see what's left over,' we said 'What does this person need and who can do which part of it.'

It would not have been in the patient's best interest to have all members of the team carrying out discrete parts of the care plan. This would likely have resulted in fragmentation, a lack of fluidity, confusion, and multiple inefficiencies. Role blurring in

this context was a conscious choice, it was seen as a necessity, a positive consequence of client centred practice. There was an openness to a different way of working that set it apart from other health care environments. With the firm focus on the needs of the patient, came an openness to work in a way that best enabled the patient to meet his/her needs. It was an openness to let go, to take on, to do whatever was going to benefit the patient.

In Jenny's experience, each discipline within the team contributed to the care by way of involvement in the care planning process. Although this was integral to the team based care planning process, it did not necessarily translate into the actual 'doing' of the treatment (i.e. not every discipline needed to implement what they contributed verbally in a team meeting).

The team: Relationships, dialogue and a fusion of horizons

Amy, an occupational therapist working in a mental health environment, describes an experience of working in a team who were aware of their own professional limitations in providing effective care, who were open to different perspectives and approaches, who actively engaged in dialogue and were then able to act out of their broadened horizons.

I worked at an inpatient unit for children, adolescents, and family/whanau experiencing difficulties with their mental health. An expected part of the allied health teams' role in this unit was facilitating groups. Previously groups had been run with little collaboration between the disciplines. We had a really lovely team consisting of social workers, psychologists, occupational therapists, nurses, and cultural support at that time. We met together regularly and decided it would be much more valuable, with better outcomes for our client group, if we provided the groups together recognising that we all had different strengths that we could offer. We planned the groups together and divided the tasks up depending on our interests, expertise, and comfort level, so we had really clear roles. Afterwards we would always meet and talk about what we'd done well and what we could do differently next time.

This team was open to working together; they engaged in dialogue, and in dialogue became aware of the limitations in their own background understandings; in this case, that more could be achieved together than it could be on their own. "Through encounters with other traditions and other people, we are challenged to enlarge our background understanding to achieve an improved understanding of a topic or subject" (Polkinghorne, 2000, p. 471). Through an iterative process of dialogue, the team were challenged to enlarge their background understandings, to broaden their horizons, which improved their understanding and approach to caring for their patients (Polkinghorne,

2000). This opened the way for collaborative practice to take shape, to be sharpened and modified through ongoing questioning and reflection.

Amy's team was one where mutual respect presided, where the contribution of others was valued, where good interprofessional relationships were developed and sustained, and where mechanisms were in place to support collaborative practices.

Some of the qualities that contributed to collaborative group work being successful were that there was real awareness and a sense of mutual respect for the roles and expertise of each of the disciplines within the team. There wasn't a sense that one discipline was more important or significant than the other. We were all committed to providing the best outcomes for the young people. There's a lovely kind of an adage that they say in youth health, 'it doesn't matter who gives it, so long as the young person gets it,' so I think people weren't precious about their roles. It was more a sense of 'who are we here for and what are we doing?' I think the fact that we got along well and had good relationships with one another with a fun atmosphere within the team really enticed people to work together. It was just really enjoyable and a really lovely way I guess of building on each other's expertise. It became part of the expected culture of the place. The team was in a sense given permission to work together, it just made it more normal I suppose. When you have a positive experience, it makes you more likely to want to do it again. You recognise the value of someone's perspective and you don't find that out until you work with someone or you see them in action and they see you in action.

This story points to team relationships being at the heart of positive team interaction and collaborative group work. It happened because there was a willingness and openness amongst the team. This openness paved the way for positive working relationships to be developed, fostered through dialogue. The too-ing and fro-ing in dialogue opened up the space for a shared understanding of each person's strengths, interests and perspectives and how care could be different, better, for the patient group. Gadamer (1975/2013) suggested that engagement in genuine dialogue reveals something about its participants, where initial assumptions are challenged, modified and held up to scrutiny, forcing people to see things differently. This may have been the case for Amy's team, where opportunities for genuine dialogue have enabled the team to come to an understanding about how they want to work. The to and fro dynamic evident in the group planning and reflecting conversations between the different health professionals were comfortable, they appeared to be easy. This fits with Gadamer's notion of 'play' which happens without effort, it absorbs the players. There is a sense that the team's commitment and focus on providing the best care for their patients meant that they got lost in the 'game', in the 'play' of dialogue. There is also a sense that within the 'game'/dialogue there is

freedom to decide to act one way or the other, they are able to play with possibilities (Gadamer, 1975/2013).

This team were concerned about and committed to the patient receiving the best possible care. Who delivered the care did not seem to be what mattered here. The team recognised the most important thing was that the patient got the care they needed. There was an attunement; a harmony that directed how the team approached care in this situation. It was derived through the shared sense of purpose, the respect and understanding shown; and through the trust and positive relationships that were in place. Being attuned to one another and the patients allowed the team to let go of those more traditional professional roles and was strengthened by the spirit with which they engaged in interprofessional practice.

Team collaboration was fun; it gave the team a sense of confidence in themselves and each other and ‘enticed’ them to want to do it again. It inspired the collaborative approach to group work and led to a working environment that contributed to each person’s professional practice through extending their horizons in an attempt to understand the other.

The team: A caring for and trust in one another

Paula, a nurse working closely as a member of a team, describes an occasion when the ‘team-ness’ of the team was challenged. This was a situation that could have resulted in a splitting off, a fragmentation of the team, had it not been for their strong sense of togetherness, respect, support and trust for and in one another.

When I was working in a national paediatric service I can think of one patient in particular that we were transitioning into adult services where the family were quite challenging, their demands were high and kind of unreasonable at times!! But as a team we stuck together. We were very clear that we were all sending the same message to this family, that we were on the same page, and that we were all supporting each other. There was one member of the team that this particular parent seemed to have issues with, so it was about us all being supportive of that person, making sure they weren’t ever alone with this family, that we all sent the same message and communicated to them in the same way. An example of this was during one family meeting when the consultant explained to the parent that, x member of our team is very, very important in terms of what they can offer. I guess, this parent had a lot of respect for the doctor, and by highlighting the importance of the team and what everyone in the team had to offer the patient, it was putting forward a single front. So in the end, what was a negative experience for one member of the team ended up being quite a positive one.

There was a sense of loyalty that came with being a member of this team, suggestive of an ‘already there’ appreciation, attunement, understanding and respect for each other. “Dasein exists essentially for the sake of others” (M. King, 2001, p. 76). When considering Heidegger’s notion of *Fursorge*, ‘solicitude’ or the caring for others in this story, the doctor ‘leapt in’ for the sake of the other, for the sake of the team. The leaping in intervention likely came as a welcome relief for the team, one that was well judged, relieving the others of the immediate challenges of the moment. The doctor’s act of solicitude in leaping in balanced the immediate needs of the situation with the need to ensure it was less likely to happen again in the future.

Amanda raises the notion of trust and trustworthiness in interprofessional practice and the role the environment can play in promoting trust; creating a safe environment for trust to grow:

I think that language is really important in terms of providing a safe environment for trust to be enabled. Skills are important as well and the knowledge of the other team members, so you know they really can do what they say they can do, or that they have the technical skills to do whatever job is needed. That has to be part of that trust because many people can be lovely and say they communicate really well but you also need to be able to do the technical things as well.

In Amanda’s experience, in order to trust in the other, the other needs to demonstrate trustworthiness through language but also through their actions. Amanda highlights the importance of the truster having confidence in the trustee to do what they say they can do (Dinc & Gastmans, 2012). Her expectations are that the other is able to perform his/her professional roles and responsibilities. Just saying you are competent to do the job is not sufficient; it needs to show through actions.

An interprofessional practice culture appeared to flourish in situations where the team shared a sense of purpose, where the patient was their firm caring focus and where solicitude for each other was evident. In such a team, each team member’s unique contribution was retained but came together along with an openness to the letting go and taking on of expanded roles. Opportunities to develop relationships and engage in dialogue developed mutual respect, trust and expanded understandings.

The Organisational Environment

Listening and dwelling with the stories has also brought forward aspects related to the organisational environment that appear to matter in relation to what makes ‘good’ interprofessional practice. However, we cannot talk about the environment without also

referring to the other fourfold dimensions. Without good systems, processes and structures in place or the required ‘space’ at an organisational level, it would not matter how effective the leader or team was, how open to learning, or how focussed they were on the patient, good interprofessional practice would be challenging.

The organisational environment: Strategies and systems for interprofessional collaboration

Carol, a recently graduated midwife, described the logistical as well as wider institutional barriers that came into play when trying to work collaboratively.

The problem is the geography, you know, we don't go into the obstetric appointments with them all of the time. The Ministry of Health referral guidelines say we are supposed to have a 3 way conversation (client, midwife and obstetrician) but it doesn't often happen because we're in different places and there is no facility, unless we front up and put our bum on the seat. Which is a pity, because some quite big decisions are made and advice given to the women that they may not understand at the time. It really is valuable being able to attend and sit in on these appointments.

The question of whether to collaborate or not was left up to Carol, despite national health policies and local guidelines recommending collaborative practices, and despite Carol's acknowledgement of its benefits in the care of her client in this case. The challenges associated with the logistics in play often outweigh the known or perceived, but sometimes concealed benefits of working collaboratively with colleagues; practical issues which have, at the very least, a temporal and economic impact on Carol. Costs come not only from travel expenses but in taking time out of her day which could be spent doing other things.

One of my clients who is 39 weeks has an appointment with this obstetrician tomorrow and I am going to that one. I think at this stage it's crunch point. I was concerned that at her last obstetric appointment there was talk of inducing her, which is counter intuitive if you don't want somebody to bleed (which we don't in this case because she won't consent to blood products). So even though it's a 120km round trip I think it's worth going to. I can support my client and we can all have a proper conversation and give the woman options to think about. So hopefully she'll feel supported and I will get the information I need about how to manage the situation appropriately. Invariably we are going to have our own questions, so we can just ask them, it saves a lot of time. It also saves a lot of thinking about whether I should worry about something or not. To a degree it also makes us feel more supported because we have taken the decision and responsibility together. So in some ways we know that somebody else has our

back in some regard. So it's really good from our perspective to be there to participate.

Carol not only recognised her presence at the appointment as important for her client's well-being, but also for herself and the organisation she works for. Bringing together each other's perspectives, understanding these differing viewpoints, recognising the potential impact of these, and finding a shared way forward would ensure a safer outcome for the client. She had not been to other appointments, she had not made the 120km round trip with this client before, however there was something about this appointment, at this time, that alerted her to its importance. Her concerns about care called her to collaborate; the need to feel safe for herself and for the client prompted the collaboration. She sensed that despite the distance travelled, it would, in the end save time. It would save her worry; it would allay her fears for her client. Attending this appointment would provide Carol, the obstetrician and the client with the opportunity for questions and answers, for the too-ing and fro-ing in dialogue, for the seeing of things in their rightful context (the background understandings of those involved), enabling the working out of a common meaning (Gadamer, 1975/2013). This engagement in dialogue and the shared meanings and actions that come as a result, also allowed a shared sense of responsibility to prevail, *'we have taken the decision and responsibility together.'*

In her story, Carol recognised that interprofessional collaboration was necessary and acted out of solicitude for her patient. She found her own way, there were no specific guidelines or processes which directed her to connect interprofessionally in this organisational environment. On the one hand there is the mandate to act in ways that privilege the client, that espouse collaborative practices, yet on the other there is a lack of space for interprofessional practice and a dearth of strategies to make it happen.

It was important to collaborate face-to-face on this occasion. The collaboration itself revealed the issues; issues of concern which may have otherwise remained covered over. Issues which, once uncovered, could then be addressed. There may have been other occasions where collaboration could have resulted in beneficial outcomes for those involved, but did not happen because the 'call' to collaborate from within or beyond was not strong enough to overcome practical obstacles.

Carol's previous experiences of interprofessional collaboration confirmed its value. She knew it was possible and describes a simple but effective interprofessional strategy.

The DHB has been running a social work based forum where midwives can ring in and be on the phone as part of the meeting when they're discussing a case.

That's an interdisciplinary meeting, so that's evidence that the system could work. It would be quite nice if that could work with the obstetric staff as well. I'm just thinking that why can't the obstetrician conference call us? You know just have us on loud speaker at the appointments. If it doesn't work it doesn't work, but the opportunity could be there. It's just a pity... sometimes it would be helpful.

The approach to patient care described came about because those within the organisation recognised and valued opportunities for interprofessional collaboration. It appears to have been driven by a small number of key individuals able to implement the collaborative initiative which prompted a working together, that worked to meet the needs of the patient, with support from the organisation. There is simplicity in this strategy from an organisational and logistical perspective.

Tony, in his role as a social worker working in child and adolescent mental health services, recounts a situation when talking and working with another agency was indicated, but where pragmatics, politics and a lack of understanding got in the way.

There's a young adolescent Tongan boy who was referred by the school. He was difficult in the classroom. There was also some sexually inappropriate behaviour, possibly some substance abuse, he was aggressive and not following directions at home. He'd been with his grandparents but he'd returned back to his biological mother and she was having difficulty. So it became really clear early on after he was assessed by mental health services that this wasn't a mental health issue that was driving this young person's behaviour, it was the fact that he was intellectually disabled. Because his behaviour was difficult to manage, it was essentially a care and protection issue related to his disability. We got into a big disagreement with them about providing support for the family. They're funded to do it, mental health services aren't. Often the behaviour is not necessarily a mental health problem but it's a reaction to the social situation. But the care and protection agency didn't see it that way. And how you convey that message and then whose responsibility is it to provide the support in a way that relieves the family's and the young person's distress gets kind of ratcheted up the food chain with politics, funding and all the rest of it getting in the way. In the end what happens is that both groups of professionals get annoyed with each other.

There is a sense that the young person and his family in this story have been lost. The focus has shifted from the person's needs to the needs and issues of the institutions involved. There is also a sense that the priority for the system was to safeguard the organisation and people who work within it rather than those they were tasked with caring for. The provision of seamless care across organisations was not there, with factors such as funding constraints, protocols and historic tensions between the organisations and professions seemingly getting in the way. This prompted caution, a lack of trust, a

reluctance to engage in dialogue, a lack of openness to listen and to come to an understanding with the other. This apparent unwillingness to engage or share risk resulted in a stalemate situation. The person losing in this scenario is the patient. The space for coming to an understanding for and with the patient was not there.

Despite an expectation to provide the best care possible and to work collaboratively across the health sector, Thomas suggests that the way the sector is structured may actually work to promote competition and siloed approaches to care rather than one of mutual collaboration. Thomas talks about the impact of different funding models and a two tiered system on interprofessional practice.

I think interprofessional practice goes back to delivering the best service to your patient, where you're providing more encompassing care, wraparound care that is actually going to make sure people don't fall through the gaps. I felt that we needed a re-jig of the way that we fund health care. And while I don't think funding is the be all and end all, funding drives behaviour and definitely in my profession it does. When you have 65% of all physios going on to work in private practice, the way you get paid is going to make a big difference. So I think funding needs to be redressed. I think if the powers that be alter the way that we fund health care, that health professionals will come on board. There's huge barriers with the two tier health system between public health and ACC [Accident Compensation Corporation] which in some professions is not as big. So things like that need to change before we can actually get a team environment working properly.

Thomas alludes to other barriers which exist for interprofessional collaborative practice. The way healthcare services are structured and the way in which health care practitioners are remunerated has an impact on where and how they work. In order to ensure best care that wraps around the patient and family, there needs to be professional equity across the sector; there needs to be a focus on the patient and on improving their health outcomes. Thomas suggests that working within existing services and sectors dictates working practices and determines whether they are able or willing to work interprofessionally. Reducing these disparities across organisations and sectors would allow for a shared approach to care, one that focuses on the needs of the person and his/her family as opposed to what works best for or being constrained by the organisation.

In Jenny's experience of working in an interprofessional community rehabilitation team, it appeared that when the focus shifted from the patient to the needs of the organisation, or the organisational demands took precedence, sustaining an interprofessional model of care became challenging. Despite the interprofessional nature of the model of care, which

they were instrumental in establishing in this environment, it was unable to be safeguarded and preserved. Jenny describes how other demands within the organisation began to erode the interprofessional team approach.

The challenge was in maintaining the team dynamic. Sometimes the external demands and pressures would mean that other tasks were prioritised over this team based role. We were all part of a wider hospital, so when they were short staffed, say a speech therapist might be called on to cover something that was viewed as being more important or more acute, as soon as that happened, their ability to work flexibly would disappear. It's easy to work flexibly while you're supported to work flexibly. When the leader left, the interdisciplinary approach to teamwork went with her. After that, it sort of defaulted back to more of a multidisciplinary team. Sustaining this interdisciplinary team required strong leadership, a lot of external support and an experienced group of clinicians.

The rehabilitation service was part of a wider organisation where traditional multidisciplinary approaches dominated; a multidisciplinary way of working that was understood within the organisation and within the professions delivering the care. The erosion of the carefully developed interprofessional model of care began when there was no longer someone able to safeguard and preserve this way of working. Even with a strong leader, a leader absorbed and attuned to being with others in the delivery of interprofessional care, maintaining a less well understood, patient focussed, flexible approach to care was challenging. The responsive and flexible nature afforded by the rehabilitation team's approach was weakened when external demands within the organisation were prioritised over the care they were tasked to provide. Support from within the institution to safeguard and preserve an interprofessional approach to care was missing. The service was open to the pressures and demands of the wider organisation; it was not protected in the sense that the team worked exclusively within a ring-fenced service. Holding an interprofessional spirit was always at risk in its current environment.

The organisational environment: Shared vision and expectation for interprofessional collaboration

Tony and Jenny's experience is very different to the example below, where a team was conceived and developed specifically to function interprofessionally. Paula, a nurse working in a specialist nationwide service, reveals how 'good' interprofessional teamwork or being able to work in a 'spirit' of interprofessional practice was safeguarded and preserved when it was purposefully funded and set up to be so.

Probably the first and only time in my career where the team really felt like it worked extremely well was when I worked as part of a nationwide service which

served the needs of children with rheumatological problems. It was specifically set up and funded as a specialist multi/interdisciplinary service and included nursing, occupational therapy, physiotherapy, and medical professionals.

This service was set up with the specific agenda to be an interprofessional team based service. There was a clear mandate and people were both expected and supported to work collaboratively. The vision and the intentional development and ring-fenced resourcing of this specialist team appear to be key aspects in terms of its functioning and its sustainability. This approach was less vulnerable to erosion by external forces.

The team approach was paramount in how the service had been envisaged and developed. It was mainly an outpatient service and we developed the service in such a way that the patient really was at the centre of what we did. Although we had set roles within the team, there was also a lot of crossover of our roles. We reached a point over a period of time where our roles were quite interchangeable. We had an understanding of what the other disciplines were doing and the patients felt that they could talk to any of us about any issue. So for example the physiotherapist wouldn't necessarily make recommendations about medications, that was perhaps more what I would do, however there came a point where she felt comfortable having talked to me so many times around this issue, to give certain advice to the patients. She would always communicate and check with me that the advice she was giving was right and we would communicate that way around. So we started to overlap in some areas. It's okay to be precious about some of the things you do in your profession, but it's also okay to let go of some of that stuff sometimes too. There's not really any reason why these things couldn't be shared if we support and learn from each other. Ultimately we want the best for the patient so we don't have to be too precious about these kinds of things. We had a really collaborative working relationship that worked around the patient.

Paula's experience shows a gathering of the fourfold. Interprofessional teamwork was enabled because it was an expectation of the service; they had a clear mandate. The patient was very much in the centre and gave the team focus. They were not constrained by traditional professional boundaries or traditional multidisciplinary approaches because they had been given permission to work in this way. Paula suggests that the interchangeable roles were an important part of effective teamwork but that this had come after a period of time. They had come to have sufficient knowledge and understanding of each other's roles, to the point where they were able to discuss any aspects of care with the patient, even if it was not traditionally their role. There was a confidence to share roles when the situation dictated; when it was in the best interests of the patient.

Teamwork evolved with the development of relationships between its members, and with the understanding and trust that came when working together over time.

The organisational environment: Creating space for interprofessional practice

In Paula's story above, there was an expectation of working as a team, and with this came an openness to ways of creating 'space' for interprofessional practice to occur. Creating 'space' encompasses a way of thinking about, a way of being and a way of doing interprofessional practice. As well as providing physical space in which to put this type of care into practice "...it may be possible to open up more attentive and reflexive spaces for thinking about and working with the fluidities and complexities encountered in the 'learning' and 'doing' of professional health care work" (Radomski & Beckett, 2011, p. 87).

Interprofessional practice gathers the fourfold; gathering the leader, the team, the learning and the environment to create a space for things to unfold, for voices to come forward, for things to be. What does this space look like, which allows the leader to lead, the team to 'be', the learning to happen and where the focus is on the patient?

In the neuro rehabilitation ward where Vivian worked as a speech and language therapist, there was also an openness to creating a space for the team to 'be' a team, which was built into how things were done in this context.

Structurally they have lots built in to support that [teamwork], so there was time built in for team discussions, collaborative goal setting, we were all in mixed professional offices, you were sitting next to the OT on one shoulder and the psychologist on the other and actually I found the best learning happened in those sort of, side to side conversations and you know, quickly passing through the corridor and you have a quick catch up.

Space for the thinking, the talking, the deliberating, the planning was enabled through those more formal opportunities for collaboration, but was also enabled because of the way in which spaces had been organised. The shared offices promoted space for developing interprofessional relationships. It was a way of thinking that drove the development of practice. It was just how it happened in this environment; it was expected, it was understood. In order to work as a team, there needed to be space, systems and structures to allow them to work effectively as a team.

My experience up until then of working interprofessionally had been in a large DHB in New Zealand where it was multidisciplinary and you would just have a

meeting every now and then and tell people what you were doing. And, yeah it was more just you'd say 'Oh how are they today;' 'This is what I'm doing.' Probably the most interaction I'd have with the dieticians was where you were just talking about what food they're having. So yeah, I mean you look back and think what missed opportunities there were.

Creating spaces for interprofessional interaction and teamwork allowed Vivian to maximise the collaborative opportunities and patient care. Working in a multidisciplinary way did not allow the space for open team dialogue and collaboration. It limited the possibilities for providing better care.

Theresa, a social worker in a specialist rehabilitation unit, recognised the value of the physical space in supporting the development of relationships and in promoting a more collaborative approach to care.

When I originally started work here, the social workers had separate offices. We have had changes and all the rehab wards now have an interdisciplinary model of working. We have moved into an interdisciplinary office with the other disciplines and everybody sits together and I find that it's much more conducive to working as an interdisciplinary team. Because there are those casual conversations about a client that just happen during the day. Discussions with the occupational therapists for example about 'What's happening with their weekend leave?'; 'Is there equipment?'; 'Where are they going to go?'; and it works much better now we're sharing the same office. We get to know the OTs, physios and others better because we share the lunch room as well. It would probably be beneficial if we all had a shared lunch area.

Moving to an 'interdisciplinary' model of care and moving the 'interdisciplinary' team into the same space was a conscious decision. This decision was made because of recognition of its potentially beneficial outcomes for the team and for patient care. The casual conversations about the client were a natural consequence of the close proximity of the 'interdisciplinary' team. The co-location of the team, the sitting together, enabled team members to get to know one another, and the getting to know one another prompted them to utilise opportunities to discuss and plan patient care outside of more formal team forums. The creation of this interprofessional space promoted interprofessional practice.

An interprofessional practice culture appeared to flourish in situations where there were clear, shared expectations and resourcing for collaborative practice. In such an environment the focus on the patient drove interprofessional practices; interprofessional thinking was evident at all levels of the organisation and was considered 'business as

usual'. Sufficient space and time were incorporated to develop relationships, which in turn supported the doing and being of interprofessional care.

The Learning

Listening and dwelling with the stories has also brought forward aspects related to learning that appear to matter in relation to what makes 'good' interprofessional practice. However, we cannot talk about interprofessional learning without also referring to the other fourfold dimensions. 'Good' interprofessional practice requires an openness to learning from, with, and about one another in both formal and informal learning encounters. Without this, it would not matter how good the systems, processes and structures for interprofessional practice were, how effective the leader or team was, or how focussed they were on the patient, interprofessional practice would be challenging. Taking opportunities and being open to learning, builds understandings and is part of what it means to practice interprofessionally.

The learning: Interprofessional learning as interprofessional practice

Learning is inseparable from practice, as understandings are constructed in socially negotiated practice contexts (Radomski & Beckett, 2011). To practice is to learn, and the social nature of practice generates understandings of the world (Radomski & Beckett, 2011). The relationship between learning and social situations where learning happens is considered by Lave and Wenger (1991) to be "an integral part of generative social practice in the lived-in-world" (p. 35). The being and doing of interprofessional practice shape how we understand the world and engage in practice. Many of the stories shared in this and previous chapters have shown the embedded nature of learning in interprofessional practice. The learning which has come from this practice resulted in new and different ways of viewing the world.

Amy, an occupational therapist, shows the interwoven nature of interprofessional practice and learning, where interprofessional practice is by its very nature a mutual learning process. She describes the learning that comes from working together and seeing each other in action.

We can all pigeon hole people into, 'OTs run groups and do activities' and 'psychologists do individual therapy' and you know, but actually there's a whole lot more to it and you don't find that out until you work with someone or you see them in action and they see you in action.

The learning, the finding out, the broadening of one's perspectives and understandings comes from working together; from the 'seeing'.

Again I think it was just a willingness to work with other people and when you have a positive experience working together collaboratively with someone from another discipline, it makes you more likely to want to do it again or you recognise the value of someone's perspective or again you learn something that you didn't know about.

The positive learning experiences for Amy that came from working together generated understanding, with this emerging understanding came a valuing of the other and inspired an eagerness to continue to work in this way. Encompassed in a spirit of interprofessional practice is interprofessional learning which in turn drives interprofessional practice.

In moving into a new work environment where interprofessional practice was the expected model of care, Vivian describes a positive interprofessional learning experience with her physiotherapy colleague which felt safe for her.

Learning in an interprofessional context felt safe because of my trust in her level of experience and also realising that we were learning together, trying stuff out together, it kind of felt like we could just give stuff a go and, you know, there wasn't this perfect way of doing it and the fact that we were thinking from the client's perspective. How can we make this easier for him?

The context described by Vivian was one which modelled an interprofessional approach to care and nurtured her into this way of working. Vivian had trust in her colleague and could see that the learning was mutual. Implicit in the trust was a respect for each other and an understanding that they were finding a way together, with both parties firmly focused on what was going to be best for the patient. The relationship between Vivian and her colleague allowed them to test out different approaches to care, to give things a go. It was an accepted part of interprofessional practice.

Establishing an interprofessional learning culture is one that Allan, Bryan, Clawson, and Smith (2005) argued "requires time to become embedded in everyday practice and to achieve such a culture, shared values, aims and clear communication are essential" (p. 452). An interprofessional culture had been established in Vivian's context, where this was an expected way of working; a culture where working together was firmly embedded into what it meant to 'be' a health practitioner in this context.

There is, however, recognition that even when these pre-requisites for interprofessional learning exist, there are still organisational and structural mechanisms beyond the control

of these teams which can work to constrain such developments (Allan et al., 2005). One such constraining factor described by Paula is the silos health professionals work in.

The silos that we all sit in, in the health care system, mean that as health professionals, we don't always work very well together. I certainly think it's really important that at university, students learn about what other professions do and get to know other professionals, even on just a personal level.

Working to overcome siloed approaches to care and those mechanisms which perpetuate multidisciplinary practice is something which Paula suggests needs to start early in the education of health professionals. Paula is clear that by creating opportunities for health professional students to engage in interprofessional learning at a pre-registration level, where they not only gain an understanding of other disciplines but also get to know them as people, is an important factor in mitigating the continued siloed approach to healthcare.

Vivian believes that earlier exposure and opportunities for interprofessional learning would have enabled her to feel able and confident to work collaboratively following her undergraduate education.

If I had had an opportunity for interprofessional education in my undergraduate training, I could have made far more use of my years working in one of New Zealand's biggest DHBs on a stroke rehab ward. Instead of hurrying my clients into a broom closet and shutting the door because I didn't want anyone to see what I was doing. If I had had that exposure, a positive interprofessional experience which provided me with some sort of framework for how to work with others, I would have been able to work in this way and contribute to providing positive outcomes for my clients much earlier on.

Safe and positive opportunities for interprofessional learning that allowed Vivian to practice working with other health professionals whilst still at university, would not only have given her a framework from which to work from, but confidence in herself, her own contribution and how that contribution fitted with other members of the team.

Thomas talks about the continued concern of not wanting to look stupid, and how fear can drive people away from potential experiences which open them up to this possibility. Interprofessional practice approaches are one such experience.

I think there's got to be confidence in your own ability. You've got to be comfortable in your own skin to be able to look at others and be involved with them. You've also got to have that sense or aptitude that I don't need to know everything. How you actually get them [the student and health practitioner] to that point I think there's got to be lots of factors in the way they see the world in,

the way they've been trained, the interactions they've had. I think one of the biggest fears that drive people in professional practice and in particular around university is that people don't want to look stupid. I don't think it's so much the money or the power or the ego, it's I don't want to look like a dick. So I think that's a big driver.

Thomas suggests that, in order to practice interprofessionally, health professionals need to feel comfortable in who they are and in their contribution. The fear of looking stupid appears to be keeping people in the 'broom closet'; keeping them from opening themselves up to interprofessional practice. A lack of opportunity for students and others to see the world from various perspectives, to interact together, to actually practice and learn from, with and about others in a safe and positive environment appears to perpetuate and sustain this fear, which impacts on their ability to open themselves up to interprofessional practice. Discovering ways to enable students to develop confidence, ways which promote a thirst, not fear, for interprofessional practice is the challenge Thomas has raised.

Not having previous exposure to each other or opportunities to learn from, with, and about one another may have also been the experience for the midwife and paramedics as described by Carol below.

Interprofessional practice to me is about breaking down the concepts of us and them and being there to serve the needs of the client as best you can. Exchanging the skills that you have, bringing what you have to the table and then using them in the most effective way. Not having issues of attitude or "I know more than you," just being prepared to communicate with each other. I just think it would be helpful to have a good conversation with ambulance officers about their expectations because we don't get that. That or involve them in our role play/training days, which is always possible.

Lack of engagement in collaborative practices and dialogue limits interprofessional learning and practice. Carol suggests that a focus on the patient, an openness to others' contribution and an opportunity to talk is what is needed in order to provide the most effective care. Working collaboratively involves continuous learning about oneself and the other, which generates new understandings. Interprofessional learning described by Carol can be embedded in practice or hidden; hidden in the use and sharing of skills, but can also be more overt and formal, where others are invited into specially designed interprofessional learning activities. Either way, interprofessional learning works to promote respect and positive attitudes towards one another, to generate shared understandings and to facilitate good communication and dialogue. Despite recognition

of the benefits of interprofessional collaboration and ways in which this could be promoted, actually following through or implementing them appears challenging.

Participants' stories and perspectives would suggest that an interprofessional practice culture would flourish in situations where there was sufficient 'space' as well as willingness and openness to learn from, with and about one another. Learning in such a way would not be considered necessarily separate to practice but a natural consequence of working together; learning would broaden understandings and the possibility of providing better care. Learning in this way needs to be started early, at pre-registration level to 'normalise' it, with time to build and develop confidence and trust in the process of opening up.

What is revealed from the participants' experiences is the pivotal role of the four dimensions in safeguarding and preserving interprofessional practice. The stories highlight the embedded nature and interrelationship between the leader, the team, the environment and the learning, all of which are in play when interprofessional practice is at its best.

Summary

The participants' stories have highlighted some key aspects which appear important in safeguarding and preserving 'good' interprofessional practice. These aspects broadly fit into four interrelated dimensions: the leader, the team, the organisational environment and the learning. One cannot flourish without the others. For the spirit of interprofessional practice to be safeguarded and preserved, there needs to be a gathering of these fourfold dimensions.

Vivian a speech and language therapist shows a 'gathering' of the four dimensions in her telling of her interprofessional experience.

When I joined the team I had been working for about three or four years and hadn't worked in this type of environment before. I felt intimidated by the team, but was forced, by the nature of the clients and the culture of the place to work in a collaborative way. Time was built in for team discussions, collaborative goal setting, they had mixed professional offices where some of the best learning opportunities were realised. My experience up until then had been of working in a multidisciplinary way, where we would have a meeting every now and then and tell people what we were doing. I look back and think about the missed opportunities there were. Just learning and practising using the wheelchair and hoists in these collaborative sessions which I now feel comfortable doing if I have to, are things that have made my job easier. I've picked up other stuff from different people that I've brushed up against in my clinical experience that I just

do without thinking, things that I would not have had the opportunity to learn and practice had I continued to do individual treatment sessions in a multidisciplinary culture. So I went from being nervous and feeling like people were going to find out that I had no idea what I was doing, to feeling really excited. Excited about now having a framework for how I could work with other health professions and about the positive outcomes this way of working had for the client. This team really wanted to do the best for the clients and there was a sense that you wanted your team to be proud of you and continue to be a high performing team.

The context Vivian described was one where interprofessional working was the accepted and expected model of care. An approach to care that had been envisioned by a leader(s), who was instrumental in shaping the environment, the working and learning culture and the team. The team had a shared vision, a focus on the patient and were open to finding ways of working together which would benefit the patient. There were clear structures in place to support collaboration and communication, from team meetings to the co-location of team members where interprofessional practice and learning occurred. These structures provided a framework for working collaboratively, which meant that it was no longer mystifying for Vivian. Being put in a situation where there was no choice but to collaborate within a supportive and structured environment, meant that her feelings of anxiety and uncertainty were soon replaced with feelings of excitement and comfort. The learning that occurred broadened her understandings and enabled her to develop a trust in the process. She was able to put her trust in the team and let go of these anxieties. Vivian was able to see first-hand the positive outcomes for the patient and the impact on her own professional practice and personal development. It prompted her to reflect on previous missed opportunities of providing effective patient care, which stemmed from a lack of confidence and structures to support collaboration.

The leader, the team, the environment and the learning are all one in this story; one aspect cannot be talked about without referring to the other three. The essence of interprofessional practice and the safeguarding and preserving of its spirit happens when each of these fourfold dimensions are gathered together; when each comes into play. A compassionate and tactful leader open to and attuned to others facilitates interprofessional practice and the provision of high quality care. The team comes together with an openness to and a valuing of others, to the letting go and the taking on of roles, to engaging in dialogue which broadens understandings and allows care and trust to take hold. The organisational environment enables the team to work collaboratively; it provides the space and structures to enable teamwork to flourish. An openness to learning comes from the leader, the team and how the environment is

structured which continuously develops and supports best practice. A focus on the patient drives those giving care, and those tasked with organising and shaping health services.

“To spare and preserve means to take under our care, to look after the fourfold in its essence. What we take under our care must be kept safe” (Heidegger, 1993, p. 353). Taking care of the fourfold dimensions means to let these things be free in their essence, free to preserve and support health practitioners to work in a spirit of interprofessional practice. A spirit of interprofessional practice in all of its complexity and thrownness, needs to be safeguarded and preserved.

CHAPTER EIGHT

DISCUSSION: LEARNING TO WORK IN THE SPIRIT OF INTERPROFESSIONAL PRACTICE

Introduction

The previous findings chapters drew on the experiences of health professionals and revealed things which appeared to be at the ‘heart’ of interprofessional practice, illuminating ways of ‘being’ and ‘doing’ necessary in the turning toward, working in the spirit, and in the safeguarding and preserving of interprofessional practice. These findings point toward those things to be attuned and attentive to, that need to be safeguarded and preserved.

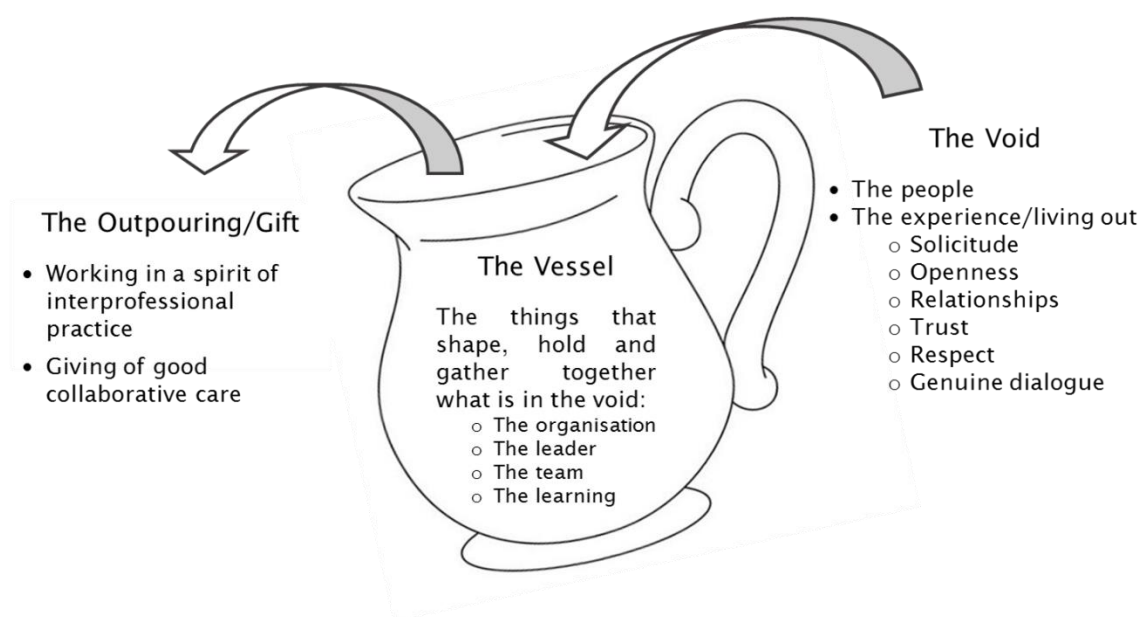
This chapter will consider the study’s original research question, ‘What are health professionals’ experiences of working with people from other disciplines?’ and consider how these experiences inform interprofessional learning in relation to the ‘thing’ (Heidegger, 1971/1975) that is interprofessional practice and the notions of interprofessional socialisation. The notion of ‘Bildung’ or ‘self-cultivation’ will also be explored in relation to the insights that emerged.

The Thing that is Interprofessional Practice

This study focused on the everyday thing that is interprofessional practice in order to “grasp how ...seemingly independent things come to be as we ordinarily find them around us” (Gendlin, 1967, p. 255). Coming closer to the ‘thingness of the thing’, in this case interprofessional practice, is to consider how things are, and how things come to be the way they are in a particular context (Gendlin, 1967).

Participants told stories that were about the things that called them to turn toward interprofessional practice, things that they considered were important in the actual doing of interprofessional practice and those things which sustained them and allowed them to continue to work in this way. There is a sense that the ways of being and doing identified in the stories are all interrelated and are at the ‘heart’ of health practitioners being able to work in a ‘spirit’ of interprofessional practice. In order to make sense of and pull together the findings of this study, in relation to the ‘thingness’ of interprofessional practice, the analogy of a jug which Heidegger used to illuminate more fully what a thing is, will be co-opted. See Figure 4.

Figure 3. The Essential Nature of Interprofessional Practice



In an objective sense, the jug is a holding vessel with a base and sides, a handle and a spout. As a vessel the jug holds something. What is poured into the jug goes into the void to be held and eventually poured out. The void is the space created by the sides and the base of the jug. It is within this void where the holding happens. What is poured in is taken and kept, and what is poured out is given as a gift (Heidegger, 1971/1975). The jug was made for a particular purpose, it is independent and self-supporting. It shows itself and its very 'whatness', in terms of what the empty space is filled with, holds and is poured out or given; which means it changes from being a mere object, as a jug, to some 'thing' that does something. Its essence, or how and what the jug is, stands forth as the "thingly character of the thing" (Heidegger, 1971/1975, p. 167). "The jug's character consists in the poured gift of the pouring out" (Heidegger, 1971/1975, p. 172). It is what happens in the void and in what is poured out of the jug that determines its character, its essential nature.

How does interprofessional practice show itself as interprofessional practice? What is poured into it that is then held, kept and nurtured, and what is poured out that determines its essential nature?

Individual health professionals, and health professionals within teams, come together for a particular purpose; to provide better, more holistic care in order to improve the health outcomes for the patients they work with. When health professionals come together in an interprofessional region, they exist and act in deliberate ways to achieve a specific

purpose. The interprofessional region can be considered to be the holding vessel that gathers together ways of being and doing that then determine the ‘thingness of the thing’. The thing that holds itself is not interprofessional practice; rather, it provides the void, the place where the ingredients of interprofessional practice can be gathered together and then poured out.

What is poured into the void of the interprofessional region is the people involved, along with their prejudices, preunderstandings, their solicitous nature and their moods. What holds and gathers together the people and their ways of being determines the potential of the void. Things such as:

- the organisation – its policies, systems and space for interprofessional collaboration;
- a tactful, open and attuned leader;
- a team that engages in dialogue, builds strong and trusting relationships and where there is a sharing of roles;
- and an openness to learning from, with, and about one another in both formal and informal learning encounters.

The creation of the holding vessel, the theoretical frameworks, the policies, systems and structures, space and time for collaboration, to some extent shape the possibilities of gathering. When all of the dimensions are gathered together, align and merge, with the patient at the heart, a particular essence or spirit of interprofessional practice can be free to be safeguarded and preserved. What happens in this gathering together will determine the outpouring, the turning toward or away from interprofessional practice and whether those in the void are able to work in a spirit of interprofessional practice. The turning toward or away from interprofessional practice was seen to be influenced by the calls that came from within and beyond the practitioners and was fundamentally in relation to what they cared about. How they responded to calls to collaborate was influenced by the person’s solicitous nature, prejudice and mood, as well as how pressing the clinical need was, what the expectations were and how the call was made. This living out, the experience within the void, also influenced the nature in which collaborative practice was enacted. It seemed there was something that I have named ‘spirit’ which held the patient at the heart, where the building and maintaining of positive relationships remained at the forefront, where practitioners were open to themselves and the contribution of others, where there was trust, respect and opportunities to engage in genuine dialogue. These were the things that mattered, and when these things were taken

into the void, nurtured and held, the way was open for a spirit of interprofessional practice to be poured out into care. The void is the place where all of these things are gathered together. Just putting a few people from different disciplines together into the void does not automatically mean that what they are able to give as the outpouring will be effective, or in a spirit of interprofessional practice.

For a spirit of interprofessional practice to show itself as itself, it needs to be free to be what it is. What surrounds the void that holds and gathers, allows what is in the void to show its essential nature. It safeguards and protects what is inside and needs to be shaped in such a way that it allows the void to be filled with the things that enable people to work in a spirit of interprofessional practice. For a spirit of interprofessional practice to be what it is, the team, the leader, the environment and the learning all need to be gathered together to protect it in its essence. What is put into the void, is held and kept safe and when it is ready, it is poured out, given over in the care of others. The outpouring is the consequence of this holding and gathering and is the giving of the thing that is interprofessional practice. The outpouring makes interprofessional practice the thing that it is; its character or essential nature. Being able to appropriately manifest and determine itself allows it to come into its own, to be what it is. Paying attention to the void and what happens within it is important, so that what goes in, comes out in a way that enables practitioners to work effectively together in the provision of high quality care.

The interrelationships between the interprofessional region, the things that go into the interprofessional region, what happens within the void that the interprofessional region holds, and the pouring out from the interprofessional region can be illustrated by using the metaphor of a fruit cocktail. For the essential nature of the fruit cocktail to show itself and for it to be what it is, it needs to be gathered together and held by something, a vessel, a holding jug. In the case of interprofessional practice, this is the interprofessional region where there is an expectation to collaborate, space and time provided, as well as the policies, procedures and systems that enable it to be gathered together, to be free to be what it is. What also goes into the making of a fruit cocktail are different ingredients, ingredients such as fruit juice, fizzy drinks, fruit, ice and maybe even alcohol. This might represent the different combination of people involved in the interprofessional encounter, their qualities, dispositions, knowledge, mood and preunderstandings. It is the combination of all the different ingredients that gives the fruit cocktail its flavour. The fruit cocktail is more than any one ingredient. An interprofessional team is able to offer more than any single discipline. If any one of the components that goes into making the

cocktail is changed or missing, it would change the whole cocktail, it would be very different. If there was not a patient focus, a tactful and open leader or opportunities built into practice that allowed the coming together and the engagement in dialogue, collaboration would be challenging and may look very different. Something happens in the brewing within the void that also determines its flavour. The brewing process within the interprofessional void includes the mood, the atmosphere, the learning that takes place, relationships, how open health professionals are and how care is manifested and comported, the level of trust and respect present, and whether there are opportunities for and engagement in genuine dialogue. What and how much of each ingredient and the brewing process itself, all affect the taste of the outpouring. It could be imbalanced, too sweet, too tart, tasteless, too warm, too alcoholic or not given sufficient care or time to brew effectively. Careful consideration needs to be given to what goes in, what holds and gathers, and what happens within the void in order to ensure the outpouring is just right.

How can the void present within the interprofessional region be shaped to ensure the gift of the outpouring is one where practitioners work in a spirit of interprofessional practice? This is a challenging task, given that much of what happens in the interprofessional void is unquantifiable, unmeasurable and often remains hidden in the everydayness of practice.

Interprofessional Learning through the Process of Bildung

Who we ‘are’ affects how we ‘are’ in interprofessional practice. It affects whether and how we respond to calls to work with others, the way in which we engage, and the extent to which these ways of working are prioritised, nurtured and safeguarded. Who we become, comes from an inner process of formation and the cultivation of self, or *Bildung* (Kim, 2013). It is described by Biesta (2002) as “the cultivation of the inner life, that is, of the human soul, the human mind and the human person; or, to be more precise, the person’s humanity” (p. 378). *Bildung*, for Gadamer, is the formation of the person through a process of understanding, “... human understanding is what happens within the process of *Bildung*” (Lawn & Keane, 2011, p. 18). It is an organic and natural process intimately linked to the idea of culture and is the way in which an individual becomes who he/she is, his/her humanity, contributing to the development of talents and capacities (Gadamer, 1975/2013). However, as highlighted by Nordenbo (2002), *Bildung* is not a passive process, but is acquired when a person “has assisted actively in its formation or development. In other words, in the educational context, the concept of *Bildung* contains a reference to an active core in the person” (p. 341).

Bildung is an important notion that warrants discussion here. Perhaps particularly important given the purpose of this research was to draw on practice experience to inform and shape who the learners are becoming through interprofessional learning curricula. Bildung provides a way of understanding how people ‘become’ who they are, and the qualities they acquire. It also provides a way of understanding the processes by which who they have ‘become’, can be moulded, shaped and changed in encounters with others and exposure to different perspectives; encounters with others that shape ‘being’ and ‘becoming’ and determine whether they are able to work in a spirit of interprofessional practice.

At an individual level, Bildung is characterised as a process of socialisation, through the ongoing absorption of traditions, customs and habits (Gadamer, 1975/2013). It is a way of integrating knowledge, skills and expertise with moral concerns (Bleicher, 2016), a process concerned with self-development and, at the same time, about remaining open to the ‘other’ and more universal points of view (Gadamer, 1975/2013; Stephens, 2014). Bildung occurs when an individual’s perspectives are transformed by encounters with others (Bohlin, 2013), and in encountering a new idea or perspective it becomes “an opportunity for the formation of self, as well as for transcending ones limited circumstances of habit” (Stephens, 2014, p. 203). It is the process by which limited horizons can be expanded, and where views are challenged during encounters with things and others that are new or alien (Bohlin, 2013; Gadamer, 1975/2013; Stephens, 2014).

Understandings of Bildung, as a process of learning that occurs in confrontation with different perspectives, provide the opportunity to critically reflect and assess one’s own perspective and to transform it (Bohlin, 2013). It has a role in sharpening understanding, developing moral responsibility, citizenship, critical thinking and the ability to see things from alternative perspectives (Bohlin, 2013). It is a process of learning that enables the learner to become who he/she authentically is and at the same time open to ‘teaming up’ with diverse others. It aligns with understandings of the role of education, which is about broadening horizons, the active pursuit of self-understanding, and moving beyond limited experiences (Gadamer, 1975/2013; Stephens, 2014).

The university in which I teach, the Auckland University of Technology, has a diversity action plan that states by embracing diversity and the different perspectives that come with it, the university is “better able to prepare its learners for the social, cultural and technical demands of the working environment” enabling students “to participate as global citizens in a rapidly changing and increasingly diverse world” (Auckland

University of Technology, 2015, p. 3). The plan reflects the notion of *Bildung* in the sense that it expects self-cultivation will occur when there are opportunities to learn from, with, and about people from different cultures and backgrounds. It is these opportunities that enable learners to see other perspectives and to see themselves more clearly, thereby challenging their own previously held understandings and broadening their horizon of understanding. Further, the plan states: “It has also been shown that students who interact with diverse others develop higher levels of critical and active thinking skills, demonstrate greater engagement and motivation, experience enhanced classroom discussions, and develop a greater ability to understand diverse perspectives” (AUT, 2015, p. 3). These understandings articulated within the plan, align with the notion of *Bildung*, as well as understandings of interprofessional education. Such understandings support the idea that learning from, with, and about others, prepares students for practice in complex healthcare environments. The challenge for educators is to translate such a plan into the lived experience of students; to recognise that learning is about much more than absorbing content or developing competence on technical skills. Rather, it is a very personal journey of self-realisation and transformation towards encompassing others.

Bildung is an important notion in educational philosophy, and it, along with the findings from this study, signal a shift in concern toward an ontological perspective of interprofessional education with attention given to the question of the learners’ ‘being’ and ‘becoming’ rather than epistemological concerns of what to learn and how they know (Fellenz, 2016).

Interprofessional Learning as an Ontological Endeavour

An ontological view of professional education focuses on the process of ‘being’ and ‘becoming’ a health professional, where knowing, acting and professional ways of being are integrated, as opposed to simply acquiring certain knowledge and skills. “Learning to become a professional involves not only what we know and can do, but also who we are (becoming)” (Dall’Alba, 2009, p. 34). It is a way of being-in-the-world, an orientation that brings with it something of ourselves, a commitment and a caring about the outcome (Dall’Alba & Barnacle, 2015). It is a transformative process of the self, which enables the learner to integrate and achieve skilful practice. This coming to know in the process of ‘becoming’ and ‘being’ has been argued as equally, if not more important than the knowing itself (Barnett, 2009; Dall’Alba & Barnacle, 2007; Fellenz, 2016). Knowledge and the less formal knowing that comes from being-in-the-world with others are interrelated but a shift in emphasis to incorporate an ontological view where

conceptualisations of knowing the world comes secondary to being in the world have been recommended (Barnett, 2009; Dall’Alba & Barnacle, 2007). “It is as if the journey is at least if not more important than the arrival” (Barnett, 2009, p. 433).

Bildung provides a lens to consider the nature of the learners ‘being’ and ‘becoming’ and to foster it, which would be to move away from learning that is decontextualized and directed towards individual competencies (Barnett, 2009; Fellenz, 2016). The concern with a focus on knowledge, didactic, decontextualized and individual competency based educational practices in health education, is that knowledge becomes outdated, skills can only be applied in known situations and learners are unable to address the unknown or unplanned situations that arise in the thrownness of everyday practice (Barnett, 2009; Dall’Alba & Barnacle, 2007). Knowledge and skills alone are not sufficient to prepare and transform future health practitioners for integrated, skilful and interprofessional practice (Dall’Alba, 2009):

While an emphasis on knowledge transfer or acquisition has been challenged epistemologically, there is also considerable empirical evidence that such an emphasis is inadequate in promoting student learning... A focus on knowledge acquisition leaves to students the difficult task of integrating such knowledge into practice. (Dall’Alba & Barnacle, 2007, p. 680)

In the ‘being’ and ‘becoming’ professional, questions remain as to how knowledge and skills can be effectively integrated into practice and how to support learners in this transformation (Dall’Alba & Barnacle, 2007). Bildung highlights what Fellenz (2016) referred to as its duality in the formation of the professional self. This duality comprises the person’s internal self-development, his/her goals, values and preferences, and the often competing external demands and expectations within the person’s particular social, political and cultural context. How people choose and respond to external demands such as professional regulatory body, education and profession specific requirements and expectations, and how they integrate them into who they are becoming as a professional remains “a contested activity” (Fellenz, 2016, p. 279).

The challenges for tertiary education providers in healthcare is to balance knowledge and skill acquisition with the processes necessary for learners to transform as people; that enable them to enact ways of being in the world appropriate to the context, its expectations and demands (Dall’Alba & Barnacle, 2007; Fellenz, 2016). The continuing discussions surrounding epistemological versus ontological ways of knowing and being a health professional able to integrate knowledge and skills into skilful practice, can be

extended further to consider how students become ‘interprofessional’, able to work effectively with others in complex environments.

Health professional education is widely based on adult learning theories and a competency system with an individualist orientation; however, this traditional focus on individual competencies does not assist in the development of interprofessional practice or the healthcare team (Lingard, 2012). Someone might be deemed as competent individually, but this may not translate into working as part of a team. Health education providers cannot disregard the collective competence required for teamwork, as it is a key mechanism in the provision of quality care and a growing directive in healthcare education (Lingard, 2012). They also cannot disregard how learners become who they are through the process of self-cultivation and the influences this has on developing the individual dispositions and qualities necessary for interprofessional practice. How does the tertiary health education provider work to ensure the ‘being’ and ‘becoming’ of a professional, and the ‘being’ and ‘becoming’ of an interprofessional practitioner?

In the ‘becoming’ and ‘coming-to-know’, recognition of desirable dispositions and qualities necessary for ‘being’ an interprofessional practitioner is required (Barnett, 2009). Disposition is commonly understood as a predominant attitude, outlook, state of mind, or tendency of a person’s inner spirit which determines their will or motivation and orients them to the world (Dictionary.com, 2016; Merriam Webster Dictionary, 2016). It includes qualities that are understood as the manifestation of these dispositions, the distinct features or characteristics that people or things hold (Barnett, 2009; Dictionary.com, 2016). This study has pointed toward those things considered important for the essential nature of interprofessional practice to be what it is, to enable practitioners to turn toward, work in a spirit, and safeguard and preserve this way of working. Dispositions revealed in this study were: a spirit of solicitude, of putting the patient at the heart of practice, and a willingness and openness to others. How these dispositions manifested themselves through the qualities characterised by the individuals, included respect and valuing others’ contributions, being open to oneself and others, trusting in others, being tactful and authentic, engaging in genuine dialogue, getting to know others, and comporting oneself with openness.

Heidegger (1968) recognised that learning and teaching which involves the transformation of ‘being’ is no easy task. From this study, I have recognised that an ontological shift would involve the provision of opportunities for learners to develop and integrate the dispositions and qualities for being interprofessional practitioners. I have

also discussed how an ontologically driven educational approach contrasts with the straightforward acquisition and application of knowledge predominant in contemporary universities (Dall’Alba & Barnacle, 2007). In order to provide an ontologically driven educational approach, there is a need to identify how future health practitioners ‘become’ able to work in a spirit of interprofessional practice and the things necessary to support them and their practice to respond to the reflexive nature and thrownness of everyday interprofessional practice (Fellenz, 2016).

Who and how learners become health professionals able to work in a spirit of interprofessional practice should be the central concern in interprofessional learning. Learners/health practitioners need opportunities to orient themselves to, and engage with, the world in a way that allows them to work in a spirit of interprofessional practice. Graduates require dispositions and qualities that enable them to respond to and meet the demands inherent in the complex relational world of healthcare practice, where different conceptions and expectations of interprofessional practice, knowledge and performance exist and where working across professional boundaries all come into play (Barnett, 2009; Fellenz, 2016).

The reorienting of professional education toward the integration of knowing, acting and being an interprofessional practitioner requires a shift in focus and a shift in thinking. The challenge of what Dall’Alba and Barnacle (2007) described as an “ontological turn” (p. 688) for educational systems oriented and concerned with individual achievement of competencies, to move toward learning that is treated as the development of embodied ways of knowing and ways of being, remain subordinate to an epistemological focus. Letting learners learn by creating space for them to respond reflexively to the complex, dynamic and evolving practice contexts is an important aspect of ontological application, but one which also presents difficulties in its implementation.

Interprofessional Learning through the Process of Interprofessional Socialisation

Interprofessional socialisation, as the process of bringing learners together to learn from, with, and about one another in an open and safe environment, is considered a necessary step in the development of interprofessional qualities, relationships and collaborative practices (Khalili, Orchard, Spence Laschinger, et al., 2013; Stanley et al., 2016). What this study has shown as important or at the heart of interprofessional practice is the patient. ‘Heart’ is an expression of one’s care and concern for another, a disposition that drives the health practitioner to get to know others, to build relationships, to develop trust, to be open to others and engage in dialogue which promotes understanding and the

broadening of horizons. When there are opportunities to engage with others, to get to know others, to be neighbourly without the attachment of social roles or titles (Stephens, 2014), the heart of interprofessional practice is maintained. It is in having this 'heart' that health practitioners are able to work in what might be considered a spirit of interprofessional practice. The process of interprofessional socialisation may provide the vessel from which this 'heart' can be nurtured, safeguarded and preserved.

Interprofessional socialisation recognises 'becoming' as an inner process of self-cultivation that is influenced by experience and understandings drawn from these learning and practice encounters. Interprofessional socialisation aligns with the aim of education as one of broadening the horizons of its learners, of shaping understanding, increasing self-understanding, and an approach that works to develop moral responsibility and an ability to see others' perspectives. Being confronted with differing perspectives is inherent within an interprofessional socialisation process, which in turn increases awareness of one's own position and perspectives (Bohlin, 2013). Engaging in this socialisation process and reflecting on difference can develop an openness to others' perspectives, to other ways of being and doing, to prejudice, to the identification and critical assessment of, and reflection on, alternative ways of thinking, feeling and acting, and can lead to a change in one's perspectives (Bohlin, 2013). It is a 'Becoming'.

Interprofessional socialisation takes an ontological perspective of the 'being' and 'becoming' of health professionals, which forms part of the vessel in which the heart and spirit of interprofessional practice is held, safeguarded and preserved. It recognises that the process of coming to know is equally or more important than the knowing itself and acknowledges the need to orient learning in such a way that it enables learners to cultivate certain dispositions and qualities, fostering a spirit of interprofessional practice. *Bildung* moves away from the ontic (the physical, real, factual) toward the ontological, the deeper underlying structures of reality that exist and are powerful determinants that shape interprofessional encounters. Interprofessional socialisation opens up possibilities; possibilities which are all the richer because of the underlying structures on which they have been built, a higher level of human understanding occurs through the process of *Bildung*.

This shift toward an ontological view of interprofessional learning and practice positions 'being-in-the-world' and 'coming-to-know' at the forefront. It works to develop a dual identity where learners build a sense of belonging within their own profession, while also fostering an interprofessional worldview, one of respect and a valuing of others both

personally and professionally (Khalili, Orchard, Spence Laschinger, et al., 2013). “We could argue that ‘becoming’ rather than ‘being’ represents more apt terminology in the context of lifelong learning and that for interprofessional collaborative practice [IPCP] ‘becoming’ a collective identity that acknowledges the values of all involved in care is paramount” (Thistlethwaite, 2016, p. 1085).

Interprofessional socialisation is a process which shapes the void where *Bildung*, the cultivation of self occurs. It provides the ontological view from which learners can develop and sustain the knowledge, skills, qualities and dispositions necessary for working in a spirit of interprofessional practice. The void is where learners should be free to develop the energy, dispositions and qualities for interprofessional practice; where there is freedom to act and engage in ‘social intercourse’ to develop these abilities (Sorkin, 1983). Not only do practitioners need to be free to engage collaboratively in practice, learners need to be free to learn in a way that allows them to ‘become’ interprofessional. Interprofessional socialisation acts as a vessel in which the being, doing and becoming holds, safeguards and protects the interprofessional experiences. The living out, the experience within the void, is where the dispositions and qualities identified as important in being able to work in a spirit of interprofessional practice are experienced and take hold.

An interprofessional socialisation approach in health education is responsive to the complex and relational nature of learning and practice, and works to bring learners and health practitioners together in understanding each other’s roles, in respecting and valuing others’ contribution and in forming relationships. It is what happens within the void, it is the experience, the living out, the learning from, with, and about others that contributes to the thingly character of the ‘thing’ that is interprofessional practice. It is what happens in the void that determines the nature and quality of the outpouring, the gift of working in a spirit of interprofessional practice and the delivery of high quality collaborative care to the client/patient.

An ontological approach sees professional education as a process of becoming, where knowing, acting, and professional ways of being are integrated. In order to work in a spirit of interprofessional practice, learners need certain dispositions (a way of being) and qualities (individual characteristics) which foster and enable this way of being. Having a sense of what understandings we want learners to hold, who we want them to become, and the things required to support this becoming, provides the starting point for developing an ontological approach to interprofessional education. Drawing on the

findings from this study, I have attempted to capture a possible vision for who interprofessional learners become, which would provide a platform for working in a spirit of interprofessional practice.

Self-aware learners/health practitioners who:

- Hold the patient at the heart of their practice
- Have a deep sense of care for others
- Comport themselves with an openness that engenders trust, respect and a valuing of others' perspectives and contributions
- Actively and enthusiastically build relationships through getting to know others
- Relish engagement in genuine dialogue to broaden horizons
- Come to shared/negotiated understandings in the provision of person centred, high quality and collaborative care.

Interprofessional Socialisation and Bildung in Action: A Learning Story

Drawing on my experiences of working with undergraduate students in interprofessional learning contexts, and the insights gained from undertaking this thesis, I would like to share a little of how this journey is enabling me to come nearer to an ontological vision in the development of learners' 'being' and 'becoming' interprofessional. Interprofessional socialisation is a process that has not been afforded to all health students within the health faculty where I work, which primarily remains focused on knowledge and skill acquisition. Interprofessional learning activities have principally remained adhoc, extracurricular and voluntary, with few opportunities for students to work with others in clinical practice. Despite this, a specific interprofessional practice programme was envisaged and implemented with the aim of providing an authentic interprofessional learning experience that attempts to integrate knowing, acting, and being an interprofessional practitioner. It brings students from different disciplines together in the care of a person. This is my interpretation of how this particular interprofessional learning activity facilitated interprofessional socialisation and Bildung for those students who participated:

The interprofessional diabetes programme run within the university based integrated health clinic is open to the local community and provides an environment where students from up to eight different disciplines come together in the planning and implementation of care for people with type 2 diabetes. At

the beginning of the programme students come together and get to know each other as people and their roles as health professionals. They learn what it might mean to work in a patient centred way, interprofessionally in teams in the assessment and delivery of interprofessional care. This involves each of them acting as a patient navigator and assessing, providing interventions, and evaluating the patients together in a way that positions the person at the forefront. Students lead the patient's care, drawing on each other for support, ideas, and to provide the necessary discipline-specific interventions. That the patients are positioned at the forefront enables students to focus on the patient and not their own discipline contribution, and shows itself when there is a blurring of roles, when it does not seem to matter who leads the assessment or a particular intervention. By the end of the programme the students have made new friends, they have new understandings of how they can work together in an interprofessional team environment, they are open to and have an understanding of what the role of other disciplines entails, they are able to reflect on themselves and their contribution, and recognise the value in multiple points of view. They feel safe and supported and have developed new ways of integrating knowing, acting and being in preparation for the dynamic, evolving and complex nature of the practice context. They reflected on the impact this had on their clients – care was better.

Through this programme, and reflecting on this thesis, I have recognised the immense value that the coming together affords in relation to expanding the students' horizon of understanding and enabling the integration of discipline specific knowledge, ways of acting and ways of knowing into interprofessional contexts. The processes at work in the 'being' together were once covered over and remained hidden from my view. In the doing and being together, *Bildung* occurs in the getting to know each other as people and as professionals, in the exploration of each other's perspectives, in the making of meaning and coming to understandings, in the decision making; this is the everyday doing of practice. It is this process, one of self-cultivation, that facilitates the development of the qualities and dispositions that foster learners to work in the spirit of interprofessional practice.

I have been reminded that the environment, within which the doing and being of interprofessional practice occurs, is an integral part of becoming interprofessional. It needs to be an enabling environment, one that expects and provides mechanisms for

interprofessional practice; one that remains open and caring, lets students learn and gather together, safeguards and preserves this way of working. In the example described above, the knowing about diabetes itself became less of a focus; what became more apparent was the importance of the process of ‘becoming’. The process of interprofessional socialisation that enabled the students to be exposed to other perspectives and ways of practising allowed them to reflect on and to question their own perspectives, approaches and ways of being. It is these opportunities which act to enable students to work in a spirit of interprofessional practice. My learning from this programme and thesis have occurred in parallel with the insights gained from my thesis invested back into my teaching practice.

Implications for Practice

Despite the aim of this study being to draw on interprofessional practice insights to inform interprofessional learning, a number of valuable insights into areas related to practice that would benefit from further consideration have been identified. This thesis supports and reinforces what is already understood as central in the provision of effective healthcare; the patient. When the patient remains at the ‘heart’, working collaboratively and working in a spirit of interprofessional practice is more likely to follow. Ensuring the people and the processes in practice are geared toward the patient will generate a spirit of interprofessional practice as the outpouring, the gift.

What shows itself from this thesis as important for interprofessional practice has to do both with what happens in the void, and with what goes in; how it is held together and shaped. Recognition of the equiprimordial nature of the things at play in the ‘being’, ‘doing’ and ‘becoming’ of an interprofessional practitioner is an important consideration in the development, safeguarding and preserving of a spirit of interprofessional practice. This study revealed aspects within the organisation, the leader, the team and the learning, as fundamental to interprofessional practice, which have implications for health practitioners, planners, funders and managers. Thoughts drawn from the findings have pointed toward ways in which interprofessional practice could be better, and ways in which it might be safeguarded and preserved.

The environment/organisation

Participants revealed the powerful influence of the environment and organisational structures in facilitating or compromising interprofessional working. If the health sector is serious about developing and supporting interprofessional collaborative practice, there

needs to be an aspiration towards an interprofessional approach to care, a shared set of values, and a mood that is supportive of this way of being and doing. A shared interprofessional vision can only be made possible and safeguarded when there is a collective understanding of the ways in which it might be enacted. A collective interprofessional understanding or vision with the structures in place to support it, needs to be one that allows its health practitioners to be free to work in a spirit of interprofessional practice. One that has the patient firmly in focus, which allows practitioners to work flexibly, to share roles, that recognises and works to address issues of competition, power, hierarchy and siloed practices. Such an approach to care that is transparent and does not become vulnerable to the demands and external pressures to conform to more traditional uni- or multidisciplinary care approaches.

A vision of care without the necessary resources to implement it is not sustainable. Environmental and organisational factors influencing the implementation of interprofessional practice identified by participants included 'space' for interprofessional practice to take place, to take hold: space and time for interprofessional thinking and reflecting, as well as physical space such as the co-location of practitioners and room to come together, to talk, plan, learn and reflect collaboratively. Time was a factor; it takes time to come to know others. Planning and delivery of care with others may initially take longer. However, there was a recognition and appreciation that although collaboration might have appeared to be resource intensive on occasions, it worked to save time and potential problems further down the line.

The leader

Participants' stories revealed features in a leader that inspired, supported and sustained a culture and spirit of interprofessional practice. Features such as a strong focus on the patient, a caring leader able to empower others, a leader open to others and to the possibilities of how things could be different, better, for the patient. Interprofessional practice was seen to be fostered by leaders who showed tact and were attuned to themselves and those around them, drawing them in and creating a safe environment, offering a platform from which to build trusting relationships.

The leader is central in the pursuit of an interprofessional culture where a spirit of interprofessional practice can be free to be what it is, to flourish. Little came through which indicated that knowledge or experience were necessary prerequisites for a 'good' interprofessional leader. What was revealed as more important was the person; their

‘being’, their solicitous nature. Finding and appointing leaders with the right qualities and dispositions to inspire, to support, to empower and provide a safe environment from which to work in the complex world of interprofessional practice is what matters. It is in management’s hands to appoint such leaders, assisted by the inclusion of these dispositional qualities within job descriptions and embedded within key performance indicators. They cannot ‘manage’ the day to day enacting of leadership. That happens within the void which is influenced by workload, group dynamics, resources, mood and so much more. They can however be attuned to a leader’s feedback on how enabling the context is to enact the vision of interprofessional practice.

The team

What came through from the stories was that when there were opportunities to develop relationships and engage in genuine dialogue, a sense of mutual respect, trust and expanded understandings followed. An interprofessional practice culture flourished in situations where the team had opportunities to get to know one another as people and health professionals, and when there was a shared sense of purpose, where the patient was their focus and where solicitude for each other and the patient was evident. When the focus on the patient led to an openness to work in ways that best enabled the patient to meet his/her needs, the team were open to letting go, to taking on, to doing whatever was necessary for the patient. The sharing of roles came naturally and was just a part of what it meant to be an interprofessional practitioner. This was evident in the organisational mantra shared by one of the participants that shaped the way in which the team came together; *“it doesn’t matter who gives it, as long as the person gets it”* (Amy).

Opportunities for team members to talk to one another, to question and reflect together, worked to enlarge their background understandings, to broaden their horizons, which opened the way for collaborative practice and better care to take shape, to be sharpened and modified. Teams need to be free to live out, to experience interprofessional practice for what it is, with opportunities to get to know one another, to come together and to ‘be’. There needs to be opportunities for team members to identify any barriers that prevent them from enacting the vision of interprofessional practice. Within my experience of practice, and reflected in some of the participants’ stories, even one negative member can undermine the enthusiasm of the whole team.

The learning

Interprofessional learning comes from engaging in interprofessional practice; it is a natural consequence of working together. Learning drives practice and the social nature of practice generates understanding. Learning from, with, and about others in interprofessional encounters enables a ‘seeing’ of the world in new and different ways. It builds confidence and trust in the process of opening oneself to the possibilities.

Positive experiences of interprofessional learning at both pre- and post-registration levels work to overcome siloed perspectives and approaches to care. Interprofessional learning promotes respect and positive attitudes towards one another, generates shared understandings and facilitates good communication and dialogue. Constructing an environment where interprofessional practice is considered ‘business as usual’ creates a platform for interprofessional learning, learning that is formal and informal, spontaneous and planned. However just bringing people together does not automatically mean they will know how, or want to, work and learn together. For interprofessional learning to take hold and flourish in practice, a collaborative culture is required. Such a culture espouses trust, respect and an openness toward one another, along with clear expectations, guidelines, and resources to support the learning and doing.

Given the embedded nature of learning and practice, if the health and education sectors are serious about developing collaborative practices, health practitioners need to be supported in the process of learning and working together. Being exposed to interprofessional practices early on in one’s journey to becoming a health professional might not only promote understanding, respect and a valuing of other disciplines contribution to care, but build confidence and provide a framework for how collaboration may be enabled in the future. Health and education sectors need to align more closely in the development and delivery of interprofessional learning, whether at an under- or post-graduate level. There is increasing awareness that to maximize positive impacts on health, education systems need to be embedded in health systems (Pálsdóttir et al., 2016). The practice context provides an authentic environment from which undergraduate health students can learn how to enact this approach to care and can embed this way of working and thinking into who they become as health professionals.

If the New Zealand health sector is serious about growing and providing a workforce that is people centred and responsive to local need, efficient, cohesive, integrated and able to work collaboratively as ‘one team’ in the provision of joined-up care (Ministry of Health, 2016), then a consensus between and amongst stakeholders and a clear plan to address

the challenges associated with reconciling collaborative learning and practice expectations is necessary.

The recent WHO (2016a) framework for integrated and people centred care identified five interdependent strategies or interventions necessary for the development, delivery and sustainability of effective and efficient people centred healthcare. The five strategies include the empowerment and engagement of individuals and communities, building of strong governance, development and adoption of a clear model of care, coordinated and inter-sectorial collaboration and the creation of enabling environments (WHO, 2016a). All of these strategies resonate with the findings from this study. Placing the person, his/her family and communities at the centre of care, acting out of solicitude and empowering him/her to voice his/her needs in the co-production of care, builds stronger relationships. Reciprocal relationships help to build trust, confidence, and mutual respect and drive the will to collaborate. The building of a shared vision, one that works to provide the best possible outcomes, relies on robust systems and good governance. The environment, the structures and systems, leadership and policies can act to safeguard and preserve collaborative ways of ‘being’ and ‘doing’ in the workplace, and are necessary for sustaining coordination and collaboration within and between health and education sectors.

Implications for Education

Notwithstanding the role of the environment and organisational forces in safeguarding and preserving interprofessional practice, a combination of qualities and dispositions have been revealed as central for enabling health practitioners to be able to work in a spirit of interprofessional practice. As these are interrelated, no one thing stands on its own. There is a sense from the stories that when the patient is held at the heart, collaboration is a natural consequence – it comes when what is best for the patient is put at the forefront. Patient centred care drives the spirit with which health practitioners engage in interprofessional practice, but there are other ingredients that work to create an environment from which the spirit of interprofessional is free to ‘be’; where interprofessional practice flourishes. Ingredients that matter are health practitioners’ solicitous nature, comportment, openness, awareness of preunderstandings and prejudice, recognition of limitations, the development of trust, the coming to know others as people as well as health practitioners, engagement in genuine dialogue and the valuing and respecting of the role and contribution of others. As noted by Oandasan and Reeves (2005) in a review of the interprofessional literature, “We know many of the ingredients

that are needed, but may not be sure how best to mix them together to create effective interprofessional education [IPE]” (p. 34). Given the central role these particular qualities and dispositions have had in determining and shaping interprofessional practice, how can an interprofessional socialisation/interprofessional education process best be developed and nurtured?

These insights and the insights into educational processes gained throughout this journey, bring into view another voice. This voice is not bound by the dominant, ontic, epistemological world of contemporary health education and practice; rather, it is a voice that moves beyond understandings of knowledge and competence, to a world that takes the spirit of interprofessional practice along with it. It is a world that recognises what lies within the person, on his/her ‘being’ and ‘becoming’ able to work in the spirit of interprofessional practice. Education is about influencing the person. We become who we are and come to understand the world through a process of socialisation and self-cultivation, *Bildung*. ‘Being’ and ‘knowing’ are inextricably linked (Heidegger, 1927/1962), in that “formal or propositional knowledge, and the informal kind of knowing that emerges out of being-in-the-world, are interrelated” (Dall’Alba & Barnacle, 2007, p. 683). There is an interface between learning that comes from being-in-the-world and developing the qualities and dispositions necessary in ‘being’ and ‘becoming’ interprofessional, and the learning that comes from knowledge and skills acquisition and competency based approaches to education. Learning that works to foster a caring attitude/outlook, openness, self-awareness, respect, and trust, transforms and broadens horizons. It opens learners’ minds to difference and possibilities, and engagement in dialogue promotes understandings that may work to enable learners to more effectively implement/utilise their knowledge and skills.

In weighing up the epistemological versus ontological approaches to education, socialising health professionals in the pursuit of self-understanding, the understanding of others and the dispositional qualities identified for interprofessional practice, without being weighed down or burdened by titles or social status, seems to be an important first step in health education to ensure the effective utilisation of profession specific knowledge and skills.

Advancing the interprofessional socialisation agenda

“We urgently need to keep students’ appreciation and commitment to interprofessional education, practice and collaboration (IPE/IPP/IPC) alive after they graduate and begin

practicing. Sadly, at present this is seldom the case” (Gilbert & Rose, 2016, p. vii). The keeping of interprofessional practice alive through the advancement of an interprofessional socialisation agenda is no easy task.

Health education providers need to provide appropriate ways of ‘being’, ‘knowing’ and ‘acting’ in the process of becoming interprofessional that are aligned and embedded into the curricula across disciplines. Bringing interprofessional learning into reality in ways that hold and sustain it, is to structure it in such a way that it becomes ‘institutionalised’ or ‘business as usual’. Consideration of the following points may assist in bringing an ontological view into reality:

- Having a faculty wide vision in which the learning to ‘become’ not only includes what to know and do, but also who the person is ‘becoming’.
- Identifying what is necessary in ‘becoming’ able to work in the spirit of interprofessional practice and the things necessary to support learners and their practice to respond to the reflexive nature and thrownness of everyday interprofessional practice. This moves away from competency constrained education, toward one that considers the dispositional qualities necessary to be able to work in a spirit of interprofessional practice.
- Re-examining curricular content specifically in relation to its epistemological versus ontological dimensions. Working to achieve a balance between learners ‘being-in-the-world’ with particular attention given to the development of the dispositional qualities that provide a foundation for future collaborative practice, and ‘knowing-the-world’ or the development of profession-specific knowledge and skills.
- Developing an interprofessional socialisation process by which learners acquire the necessary qualities and dispositions to be able to work in a spirit of interprofessional practice that aligns or is underpinned by conceptual models of interprofessional education.
- A shared approach to the reconfiguration of health professional education, where programmes are aligned and structures put in place to support interprofessional learning.
- Creating space for staff to become skilful interprofessional facilitators, able to let learning happen within a safe environment.
- Creating spaces where learners can come to dwell with one another, to think and learn together in unfamiliar, unpredictable and maybe confronting ways that promote an understanding of differing perspectives and open them up to alternative possibilities

in order to provide critical, self-reflective learning, and playful opportunities to broaden and fuse horizons.

Implications for Research

This thesis points to the ‘being’ of health professionals, their dispositions and qualities, as central for a spirit of interprofessional practice to be enacted. Further exploration of what it means to be an interprofessional practitioner and the specific qualities and dispositions health practitioners perceive as necessary for a spirit of interprofessional practice to take hold, would be beneficial to further shape interprofessional learning. This research sampled a small number of participants’ stories of interprofessional practice as a whole. The gathering of stories more specifically focussed on interprofessional qualities and dispositions would work to further support understandings gained in this study.

In addition, knowledge of the conditions under which learners/health practitioners formed these characteristics in the process of ‘becoming’ able to work in a spirit of interprofessional practice is necessary. It is the process of ‘becoming’ interprofessional that ought to be of concern for those tasked with educating the future health workforce. An ontological shift in health professional education can open the way for learners to integrate who they are, what they know and how they act (Dall’Alba, 2009; Dall’Alba & Barnacle, 2007) appropriate for the complex world of interprofessional practice. However, the question remains as to whether this ontological shift in health education is “conducive to the kind of outcomes both students and society, more broadly, are seeking” (Dall’Alba & Barnacle, 2007, p. 689). What works, for whom, at individual and organisational levels and the longer term behaviour and systems change as a result, would benefit from further investigation. There is not enough known about the impact of different contextualised professional and interprofessional socialisation processes on the outcomes of undergraduate interprofessional education or what this means for graduate interprofessional practice.

There are many factors that work to both enable as well as constrain interprofessional education and practice; factors which are at work within and around the interprofessional practice region. Awareness of such factors and their impact on interprofessional education, practice and health outcomes, would enable health educators, leaders, managers, funders and planners to better direct resources, better prepare the workforce and plan services in such a way that the barriers/constraints are minimised and the enablers enhanced, safeguarded and preserved.

A critical perspective would enable the exploration of inequalities that underpin the health professions and impact on interprofessional practice and education. Whilst recognising that within the dynamic practice context there will always be tensions, exploration of phenomena such as power and status would reveal underlying power issues more explicitly. How the interprofessional region is formed, shaped and safeguarded limits or enables the spirit of interprofessional practice. Drawing on the notions of Bourdieu (1997) and Jones (2000) in terms of the interplay of the different types of power (cultural, social, symbolic, political, economic), it is recognised that power permeates and is always in play. This study leads well into further research from a critical perspective and would provide valuable insights to inform both interprofessional education and practice approaches.

Limitations of Study

In keeping with the methodology used in this study, I sought to open questioning and provoke thinking rather than provide answers or solutions to the issues identified. The findings provide an illumination of experience and the possibility of how things could be better. The study has uncovered meanings of being an interprofessional practitioner and what working in a spirit of interprofessional practice might look like, but there is so much more to explore and reveal that remains hidden and not yet known. What has remained hidden from my view has been closed down because of the fore-structures of understanding that I brought to the study and how I interpreted and pursued the data collected. The study pointed to a way forward, a way of being in the world; a way of being interprofessional based on the lived experience of some practitioners, from some health professions, working in some contexts at particular points in time. It did not represent the voices of all health professionals, although the stories and interpretations may resonate with others.

The recruitment materials I used drew me toward people who had stories of interprofessional practice to tell, not to people who might be retreating from, or blocking interprofessional practice; people who had tried and failed. I am not to know what other insights they might have shared.

I was drawn to focus more on those factors that contributed to, and that I felt worked to promote a spirit of interprofessional practice. Those things which worked to constrain interprofessional practice were not dwelled on in any depth in this study. At the start of this journey I did not know what the stories would reveal, therefore deeper more focussed questioning and interpretation related to the three themes – the call, the spirit, and the

safeguarding and preserving aspects, only began to develop in my thinking/listening/responding within the later interviews.

Conclusion

In drawing on, and making sense of participants' experiences of working with people from other disciplines, the findings from this study reveal that who the person is, the individual qualities and dispositions that he/she brings to interprofessional practice and the context within which the interprofessional practice occurs, are what matters most. The importance of interprofessional competencies is recognised, but in themselves are not sufficient. The ontological view of interprofessional practice and education taken in this study has enabled a more nuanced understanding/speaking of the ontic.

Much of what makes interprofessional practice what it is, its 'thingness', remains hidden from view and open to the thrownness of the world of practice. The situation is open to prejudice and to mood, to the solicitous nature of the people and to the context that holds and shapes the void where living out the experience of interprofessional practice occurs.

The findings present a view of interprofessional practice that shows what goes into the mix, what happens within the experience, how this is shaped, held and gathered together, all work to determine the outpouring or gift – the spirit with which interprofessional practice is given and infused. Working in a spirit of interprofessional practice happens when the interprofessional region acts to safeguard and protect what is inside, allowing it to be what it is; to show its essential nature. What goes into the interprofessional void is people, and when the individual qualities and dispositions identified and drawn from participants' stories come into play, are held and safeguarded, the gift of interprofessional practice is given over in the care of others.

Health educators have a role in preparing learners to move into the interprofessional void and to experience interprofessional practice. It is a void that remains open to the thrownness of practice that is complex and ever changing. Preparing learners to move into the void, with the characteristics identified as central to 'being' an interprofessional practitioner, will go some way to enabling them to work in a spirit of interprofessional practice.

The many dimensions that come into play in the 'being' and 'doing' in interprofessional practice revealed from participants' stories, amplifies what the literature says: that achieving interprofessional practice is complex, a 'wicked' problem that presents significant challenges in the coming to shared understandings and practices.

Understanding is perhaps one of the most important gifts one human can give to another. If we learn not only with our minds but with our spirits, the meanings of experience, we might better be able to say, 'I understand'. ... Isn't that what we all wish for to be understood. (Munhall, 1994, p. 170)

The findings of this research contribute to a deeper understanding of interprofessional practice as a way of being that extends beyond known and measureable skills and knowledge, to qualities and dispositions that come from within a person and what they care about, and from experiences that shape their understandings. This study points toward interprofessional practice as being about a spirit, not a set of competencies. Who people are, what they bring and how they act is what matters.

Reflection: The Spirit of Interprofessional Practice

The spirit is within
An essential part of who I am
It shows itself when I care
Care fuels the spirit

The spirit is

Open
Self-aware
Kind
Respectful
Reciprocal
Responsive

It is a valuing of self and other

The spirit is harnessed through
Genuine dialogue
Trusting relationships
A nurturing environment

Working in the spirit inspires
It drives the desire to collaborate

The spirit is within
and reaches beyond
Gathering together
Around the client.

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APPENDICES

Appendix A: AUTECH Approval Letter



16 October 2014

Clare Hocking

Faculty of Health and Environmental Sciences

Dear Clare

Ethics Application: **14/321 How can health professionals' experiences and insights of working across disciplines inform interprofessional learning?**

Thank you for submitting your application for ethical review. I am pleased to confirm that the Auckland University of Technology Ethics Committee (AUTECH) has approved your ethics application for three years until 13 October 2017.

AUTECH suggests reflection of the effect of extending the offer of focus groups to one ethnicity only on the quality of the data collected. If there is not an unreasonably negative effect, then consideration of offering this opportunity to all participants and amendment of the Information Sheet accordingly.

AUTECH wishes to commend the researchers on the overall quality of their application.

As part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 October 2017;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 13 October 2017 or on completion of the project;

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Brenda Flood; Marion Jones; Liz Smythe

Appendix B: Flyer Invitation

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

Research: Understanding how health professionals work together

What: This research will delve into clinician's experiences of working with members of other health professions. Gaining insights into these encounters will help us develop interprofessional learning opportunities for our future health professionals.

Who: Health professionals from a range of disciplines are invited to take part

Where: A quiet place that's convenient for you

When: Between November 2014 and July 2015

How long: About an hour

Organisation: This study is part of an AUT, Doctor of Health Science qualification

Contact: If you are interested in participating in this study, please contact Brenda Flood within one week of receiving this invitation. Brenda can then provide you with more information about what is involved.

Details: Email: brenda.flood@aut.ac.nz

Ph: 09 9219008

Text: 021 2273632



Appendix C: Participant Information Sheet

Participant Information Sheet



Date Information Sheet Produced: 23/9/14

Project Title

How can health professionals' experiences and insights of working across disciplines inform interprofessional learning?

An Invitation

My name is Brenda Flood and I work at the Auckland University of Technology (AUT), Faculty of Health and Environmental Sciences. My role within the faculty is to develop, implement and evaluate interprofessional learning opportunities for students from a wide range of health disciplines. I would like to invite you to participate in this research study as part of the Doctorate of Health Science programme I am currently enrolled in. Your participation is voluntary and you may withdraw from the study at any time prior to the completion of data collection.

What is the purpose of this research?

This research aims to hear the stories and explore the experiences of health professionals working with health professionals from other disciplines within a New Zealand healthcare context. It aims to bring forward ideas that may not have been considered before, to seek a more complete understanding of what it means to work with others, illustrating how particular understandings may have come about and providing insights which may inform future action in relation to the development of interprofessional learning.

How was I identified and why am I being invited to participate in this research?

You may have heard about this study from the colleague who forwarded you the initial invitation, or you may have heard about it through your professional contacts. You have been provided this information because you have expressed an interest in finding out more about the study and you also meet the study inclusion criteria. Participants will have current and/or recent experience working with health professionals from other disciplines in the delivery of care within a New Zealand healthcare context.

What will happen in this research?

If you would like to participate in this research, it will involve an interview which will be arranged at a time and place convenient to you. It is estimated that this would take approximately 60 minutes. It is anticipated that there would be only one interview, however a second interview may be necessary in order to clarify any details, to ask for more specific details related to the origins of your understandings, or you may remember important stories/details you would like to tell. Maori participants may request to participate in a group interview instead of individual interviews if they would prefer this option. Participants are welcome to bring a support person with them to the interview.

The information you have supplied during the interview will be transcribed verbatim. Following this, narratives will be derived from the transcripts where I will be looking for the stories which lie within the transcript, re-crafting and editing the information so as to bring out its meaning and ensure the story and/or opinions stand out clearly. These narratives will then be returned to you to confirm that the meaning has not changed and that you would be happy for this information to be told in this way. The stories and information provided will then be analysed, with essential themes emerging from the data.

The information collected and used in the study is for the purposes described only and will remain confidential.

All participants will be offered a small voucher as a token of appreciation and in recognition of the time they have committed to the process.

What are the discomforts and risks?

It is not envisaged that any harm will come from participation in this research. You can withdraw from the research at any time, however depending on the point at which you wish to withdraw, it may not be possible to extricate your contribution from the analysis.

What are the benefits?

This research aims to inform the development of interprofessional learning for undergraduate health students in order that they may develop the skills, knowledge, attitudes and behaviours necessary to work interprofessionally in the provision of high quality collaborative care.

This research provides participants with an opportunity to tell their story in relation to aspects of interprofessional working and in so doing contribute to healthcare delivery in the future.

How will my privacy be protected?

Your confidentiality and those who you describe will be maintained, with all names replaced with pseudonyms and any identifying information removed from transcripts. Tape recordings and original transcripts will be assigned a code and held in locked storage in my office at AUT. Computer files will be password protected and all tapes will be destroyed after 6 years.

What are the costs of participating in this research?

The interview is estimated to take 60 minutes with a group interview taking up to 2 hours. A further interview may be necessary but this would not exceed 45mins in duration. Further time will be required to read through the recrafted transcripts and to let me know if you are happy with them, which could take between 30mins to 45mins.

What opportunity do I have to consider this invitation?

If you are interested in participating in this study, I would ask that you contact me within one week of receiving this information.

How do I agree to participate in this research?

If you would like to participate in this study, please contact me directly via email, phone or text message. I can then contact you, provide you with further information, clarify that you meet the inclusion criteria for the study and arrange a time and place to meet for the interview. Prior to the interview commencing you will be asked to complete a consent form which I will send to you in advance.

Will I receive feedback on the results of this research?

Your participation in this study will be acknowledged in the final document and you will be provided with a summary of the study if requested.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking, Email: chocking@aut.ac.nz Ph: 09 921 9162

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher contact details:	Project supervisor contact details:
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Brenda flood

Email: brenda.flood@aut.ac.nz

Ph: 09 9219008 or mob: 021 2273632

Professor Clare hocking

Email: chocking@aut.ac.nz

Ph: 09 921 9162

Approved by the Auckland University of Technology Ethics Committee on 16th October 2014, AUTC Reference number 14/321.

Appendix D: Consent Form

Consent Form



Project title: How can health professionals' experiences and insights of working across disciplines inform interprofessional learning?

Project Supervisor: Professor Clare Hocking

Researcher: Brenda Flood

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 23/9/14
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that the audio tapes and transcriptions will be kept in a password protected file on the researcher's computer with back up files stored on a portable external hard drive stored in a locked cabinet in the researcher's office.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

.....
.....
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 16th October 2014,
AUTEC Reference number 14/321.**

Appendix E: Sample of Guiding Questions

Indicative Interview/ Focus Group Questions

**Project Title:**

How can health professionals' experiences and insights of working across disciplines inform interprofessional learning?

Project Supervisor: Professor Clare Hocking

Researcher: Brenda Flood

1. Tell me about a time when you were working closely with one or more health professionals from another discipline.
2. One occasion/moment/event that went well?
3. One that was more challenging?
4. How did you feel at the time?
5. Why do you think the situation transpired as it did?
6. Could you tell me about the impact/outcomes that resulted from working with other disciplines, for yourself, the patient, and the organisation?
7. What sorts of things did you learn from your experiences working with health professionals from other disciplines?
8. What does interprofessional practice mean to you?
9. How might interprofessional practice be better in the future?

Appendix F: Intermediary Email

I am currently enrolled in the Doctor of Health Science Programme at AUT and my research is looking at health professionals' experiences and insights of working across disciplines in order to inform interprofessional learning. I would like to interview health professionals from a range of disciplines to gather their stories of working with others in the delivery of care.

In order to find and engage possible participants I require the assistance of an intermediary or person not directly involved in the study to identify people they think may be interested and who meet the study inclusion criteria. This role will involve the intermediary emailing out a flyer to up to 5 health professionals from the disciplines specified by the researcher, as well as sending out a brief follow up email.

I would like to ask if you would mind acting as an intermediary for my research. I will supply the content for the emails and the flyer, I will just need you to identify people to send the information through to, which will be based on the numbers of people required from each of the different disciplines.

The data collection phase (interviews) will hopefully commence in November through to June next year, so I will be staggering the interviews throughout this period. I would like to have some participants confirmed by October.

I have enclosed a draft copy of the participant information form for your information and a copy of the flyer which will be the initial contact made with potential participants.

If you would like further information on this role or would be happy to act in this capacity, please send me an email or give me a call on ext 9008 or 021 2273632

Thanks very much and I look forward to hearing from you.

Appendix G: Sample Mind Maps

Figure 4. Sample Mind Map Carey

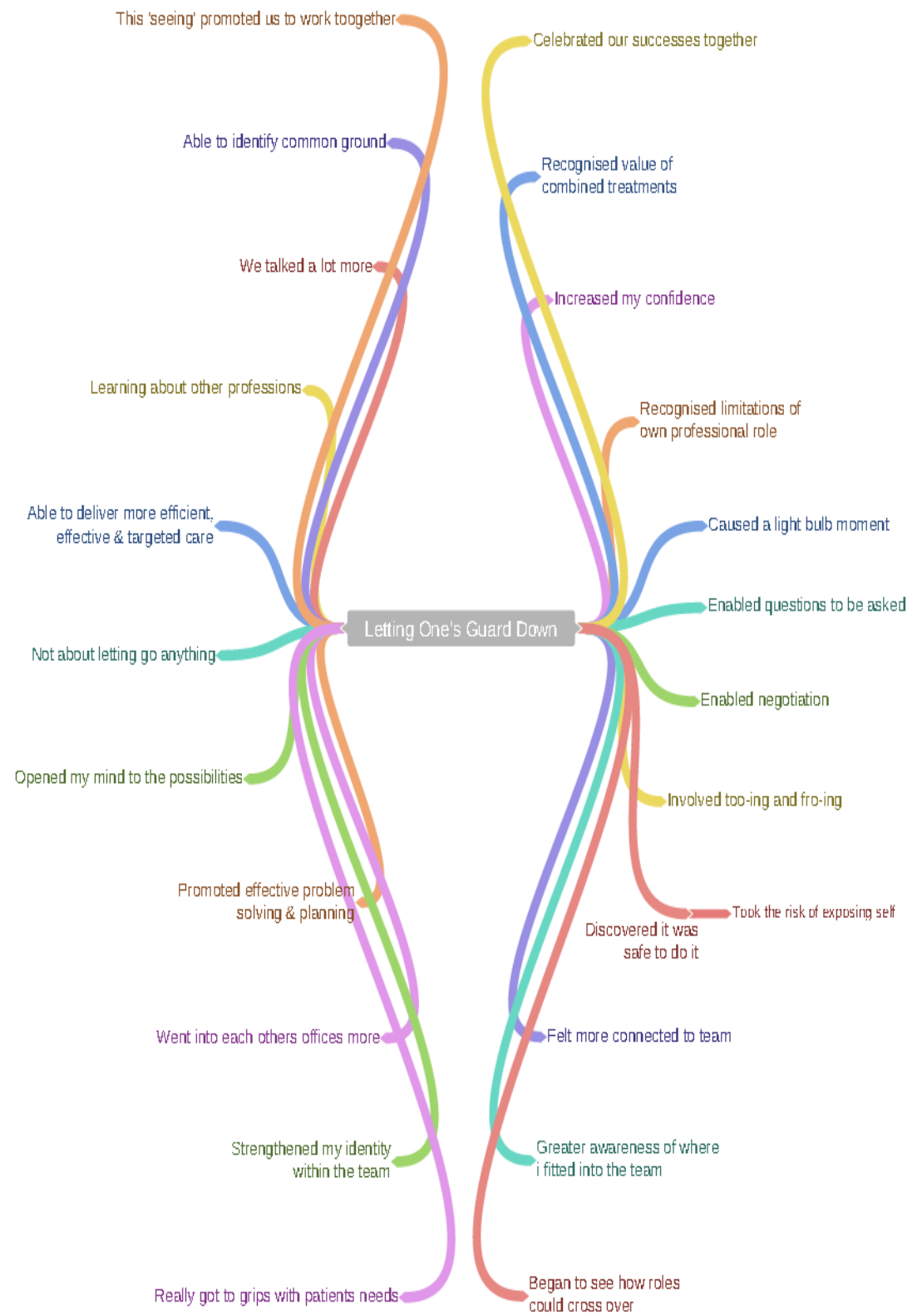
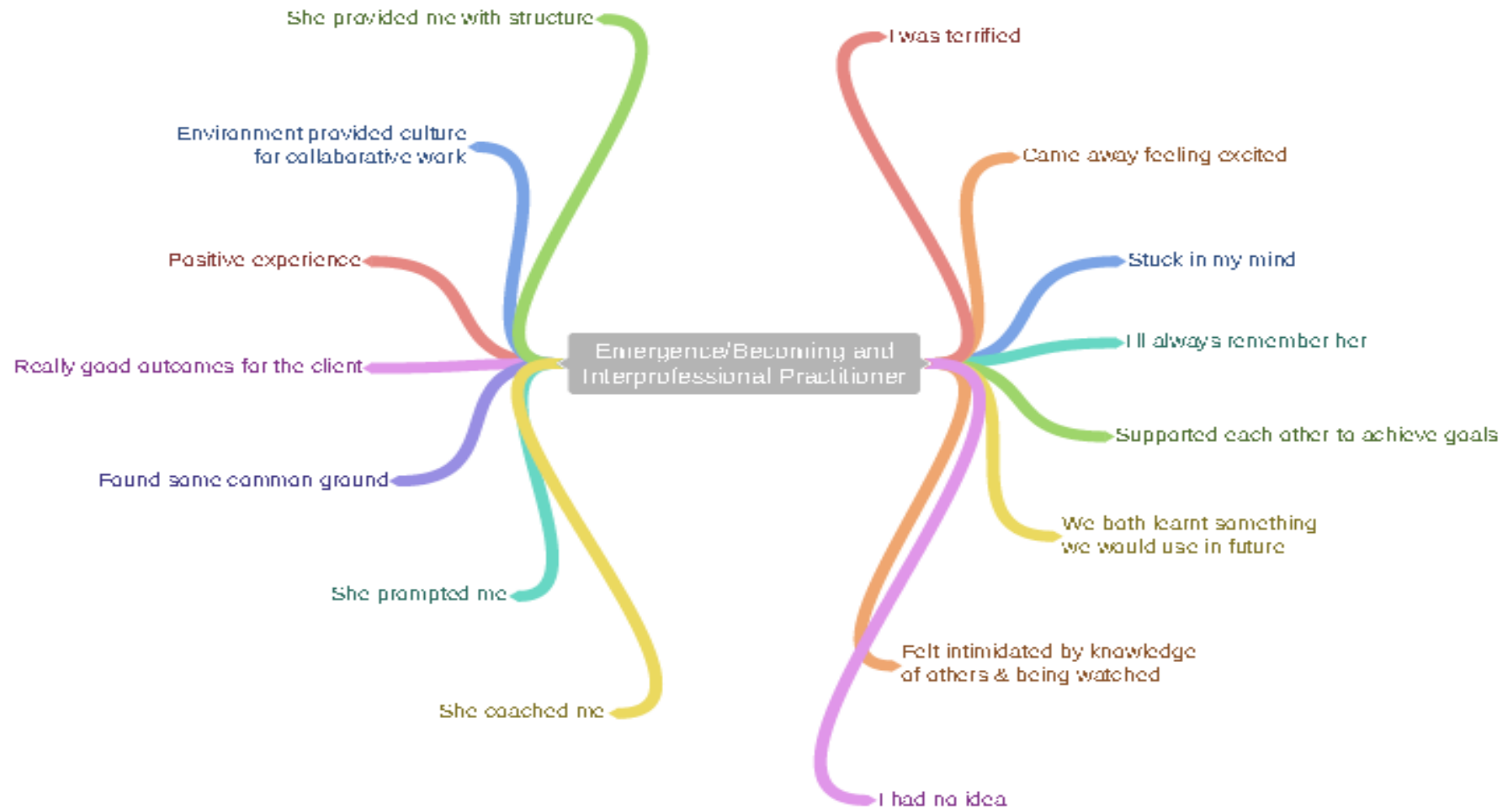


Figure 5. Sample Mind Map Vivian



Appendix H: Example of Raw Data to a Story

Raw Data

“Oh when I was working I think this is a good example comes to my mind. Um. Well what was the context again, oh yeah that’s right. They um when I was working in psych liaison and there was this, young woman, who offered those thing, herself, I think there were a lot of paracetamol or something, anyway she overdosed herself because she broke up with her boyfriend and anyway there was a lot of neural damage for that and she wouldn’t be able to function as she was before like I think this problem with her speech um capacity already she couldn’t speak, her affect becomes quite flattened um. There’s a degree of um, her mobility as well being um, ah, limited as well. Um, you know because yeah she overdosed so much and ah, and the parents were angry because of what was the thing again? The parents were angry because I, because apparently they’ve been told mixed messages because and the doctor is in the intensive care unit um because we are psych liaison we work with people who have acute psych presentations and that and they were wanting to lodge a complaint and there was myself, a reg, and a consultant um, and then I think, yeah the reg, consultant and myself yeah there was us three. Um and the conversation lasted for gosh two hours. It, it was a long conversation um, and the, I couldn’t, remember all the specifics but pretty much but the end result was really good because the family, came after that meeting with a lot more peace, peace in their heart you know peace in their situation with their daughter. And rather have come to the acceptance that she won’t be as she was before.”

Recrafted Story

“When I was working in psych liaison there was this young woman who overdosed herself because she broke up with her boyfriend. She was in the intensive care unit and there was a lot of neural damage, she wouldn’t be able to function as she had before, she couldn’t speak, her affect was quite flattened, and her mobility was limited as well. Her parents were angry because apparently they’d been told mixed messages and wanted to lodge a complaint. Psych liaison was asked to assess her. There was myself, a registrar and a consultant that met with the mother and father and the conversation lasted for, gosh, two hours and pretty much the end result was really good because the family had a lot more peace in their heart, peace in their situation with their daughter and came to the acceptance that she won’t be as she was before. It was clear that there was really limited communication between the family and the main treatment team, they were really quite frustrated, but this shifted to, okay we’re not going to complain anymore and thank you”.

Appendix I: Example of Initial Interpretation

Recrafted Story - Amanda: Knowing each other

“What made the team work well were the people and the relationships within the team. There were people in the team who knew each other. In the knowing of other’s strengths and weaknesses, there is an ease about how things will work. You know they have the skills to do the job in that situation and you don’t need to think about it or check up on them or worry about them feeling out of depth and not being able to tell you, and they also know what information you need to know about what they are doing. It enables some trust, it creates an ease and sense of relative calm. I think that it makes a real difference in terms of feelings of comfort. I don’t think it’s essential. I think you can have a team that works really well without that. But I think it takes more work in terms of communication. When you know somebody there are things that don’t need to be said. With people who I didn’t know so well, the communication was more explicit rather than implicit. When it is there, it’s great. I think it does make a difference, but the reality is that it’s not going to be there all the time or maybe even not most of the time so there are ways and means of creating that trust and that openness without necessarily having that history, but I think the history makes it easier”.

Initial Interpretation

You can focus on your own job when you know and trust that others will do theirs. It’s comfortable working with others when there is an unspoken understanding, a familiarity with how the other person works. A level of trust and understanding built over time and working practices that don’t require as much effort. An implicitness that comes from the establishment of a trusting relationship.

Does the knowing make a difference even if there is a lack of trust or a concern over somebody’s skills to complete a task? Is knowing a person’s weaknesses better because you can at least prepare yourself for this, rather than not knowing someone at all? What is it about the ‘knowing’ exactly and is it more than just knowing? What is it about the ‘knowing’ relationship that engenders comfort and an ease? Is it about creating and establishing a trusting and open relationship which provides the comfort more than the knowing (or do you have to know someone first before this can happen?) You can know someone but not have a trusting and open relationship... Is the ‘knowing’ more important when working in a resus team?

Amanda describes the knowing as important because you can to a certain extent focus on your own tasks, and in a high pressured situation like a resus emergency, you really want everyone to be able to do their jobs and not have to worry about them. The roles within a resus team are not usually profession specific, but are generic roles that they have all been trained to undertake. So

there is, or should already be, awareness of what others roles entail; there already exists an implicit understanding. You trust that everyone has done the training and despite there being different levels of experience in the team, everyone knows their own role in the situation and has an algorithm to guide the process. It would seem to me that the knowing in this type of team situation may of slightly less value than a team that doesn't have this structure (that's not to say it's not valuable, it obviously makes a difference even in this highly structured environment). Teams where there are no predetermined algorithms, where health professionals come with their profession specific skills, where there is a lack of understanding of the roles of others, where there often times is not a common client centred goal would seem to me to benefit more from the establishment of trusting and open relationships amongst team members in order to generate a special form of 'knowing'. Does this knowing entail a personal or a professional knowing and how might these things overlap?

Do teams actively encourage or support this kind of 'knowing' in their team members to facilitate patient care? Literature on transdisciplinary teams talks about the establishment of high trust teams – presumably they have come to know each other over time. How else have these relationships been enabled/facilitated and supported to develop in this way?

The importance of explicit communication is highlighted where teams don't already have trusting and open relationships and can still be effective.

Does this ease and comfort within teams contribute to our sense of job satisfaction and most importantly, better patient care?