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What Collaboration Entails: From the Traitorous to Team Care

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By means of introduction, I do research at the intersection of organizational and health communication, and this intersection is important because it influences how I think about collaboration, as well as the commitments I hold as a researcher. Specifically, I study interprofessional (IP) collaboration and communication in healthcare organizations. I work at the Université de Montréal, where I trained in the Montreal School of organizational communication, which is preoccupied with theoretically explaining the constitutive role of communication in organization at the level of interactions. The scholars in this field produce sophisticated theorizing of different organizational phenom-

ena. As a graduate student, I fell in love with the close attention paid to interaction dynamics, and with the Montreal School's commitment to studying what people *do* as they communicate. I'm sure that for most social interaction scholars, this commitment is a given.

But when we step outside of our discipline, and not even that far outside, the theoretical premise of communication as constitutive is no longer a conceptual given. On that note, I will share an experience that marked me as a researcher:

It happened many years ago, as I was analyzing data I was collecting for my doctoral research. I was observing and recording the daily meetings of 5 IP acute hospital care teams. I wanted to figure out what was collaborative about what they were doing. When I asked them about their meetings, they explained they were “just sharing the latest information.” Sometimes it seemed like they were going through a checklist. For instance, in the surgical ward, they’d mention vital signs, the patient’s diet, and whether or not they’d had a drain tube removed. And I thought, somewhat desperately, it can’t just be information transmission! What’s the point of my disciplinary training?

But as I worked with the data, I realized something important: In their interactions, they collectively highlighted changes in state. In other words, they were telling abbreviated stories about each patient to figure out what they needed to do: They were doing codified narrative sensemaking. At the time, it was an amazing discovery because, ontologically, I could put my finger on what their collaborative practice was.

One of my supervisors, John, who is a big name on the IP collaboration scene in Canada, encouraged me to present my research at an IP collaboration conference. So, there I was, standing next to my poster in the very back of a giant conference room, waiting for people to come by. Of course, nobody was coming by. So, John sent one of his colleagues over, probably out of pity. She was a physician researcher, I knew her name, and I was excited to meet her. I wanted maybe even to impress her as I described my findings of narrative sensemaking. So, I finished my little talk, and I was waiting for her “interesting questions.” That’s when she dropped the bomb: She said to me, a bit perplexed and rather dismissively, “But, that’s just your interpretation!”

I was shocked. I didn’t know how to respond. “Of course! It’s interpretive, constructionist, qualitative research!” But I didn’t say that, because, naïvely, I didn’t realize we were speaking different research languages. And—importantly—neither did she.

For a while, I retreated to my disciplinary safe zone and only exchanged with other communication and constructionist scholars, because I’m happy in that zone. But I also have a keen appreciation for scientific inquiry that targets real life problems, and it has always felt important that my research can be practically meaningful to the organizations who open their doors to me, which is why I’m drawn to health communication. Hence, I hold a dual commitment as a researcher; on the one hand, to a social constructionist approach that examines communicative practices and what we as social actors do with them, and, on the other, to an engaged approach to research that takes inspiration from the field of practice and puts theory to work.

Yet, as my story attests, this dual commitment can create a certain paradigmatic tension, especially in identifying research goals and translating research findings (e.g., Czarniawska, 2001). I’m talking about the tension between a functionalist (or post-positivist) paradigm and pretty much any other research paradigm, any variant of an interpretive or a critical approach.

In my view, the tension stems from the fact that organizational stakeholders—and their funders—want actionable research results. For instance, during my post-doctoral research in primary care, I worked with a programme evaluation statistician—about as far from constructionist interaction research as you can get—and she would ask me, “That’s nice to know, but how can I operationalize it?” In other words, what’s the point of your research?

My response to her still is: Stakeholders may unwittingly hold unquestioned conceptions of the communication phenomena we study. The result is that communication often gets black-boxed for them: too simple to merit close attention but too complex to measure. So, my hope is that as communication scholars, we can step outside our disciplinary boundaries and dialogue in a collaborative manner with stakeholders, so our expertise and research findings can make a positive difference.

Keeping this paradigmatic tension in mind, I'll focus on three provocative questions: (a) Why study collaboration? How do we define it? What themes does it invite us to examine? (b) What is communication's role with regard collaboration? How does our paradigm influence how we see communication? (c) What implications follow from our answers to these questions?

Why and What is Collaboration?

Collaboration is an increasingly popular topic, in both academic and practice circles. In practice, collaboration is highly valued by many organizations in Western societies. It is thought to improve employee task performance, motivation to stay on task, as well as organizational engagement (e.g., Carr & Walton, 2014). Collaboration and innovation are often linked (Dodgson, 2014). For instance, in universities, collaboration across disciplinary and departmental boundaries is actively encouraged, especially by many research funding bodies these days.

More broadly, collaboration is invoked as a way to address complex problems in a progressively interdependent world. In organizational communication, some specialists claim that, starting around 2010, we are witnessing "the

collaborative turn" (Keyton, 2017, p. 10), due to three practical realities (see Koschmann et al., 2010). First is the prevalence of intractable and complex problems beyond the scope of any one individual, organization, or government, but that affect many stakeholders, for instance, the problems of climate change, or healthcare systems in crisis. Second is growing interdependence between stakeholders. At a macro level, this is especially true in our economically global societies. Third is the growing number of stakeholders required to tackle these complex problems. In short, collaboration is seen as a remedy to issues of increasing complexity.

"Collaboration as remedy" is a prevalent discourse in health care. For example, IP collaboration is championed as a way to address fragmentation in expert, specialist, or professional knowledge. It is also touted as a means to address the rise in complex health problems that an aging population brings: Too much complexity means nobody can treat the patient effectively on their own. The benefits of collaboration in healthcare organizations include reducing redundancies in testing and treatment, and thereby lowering costs, and improving patient satisfaction and the overall quality of care (World Health Organization, 2010). Another trending discourse focuses on patient-centred care, where a collaborative approach means treating the person receiving care as a partner (A. Fox & Reeves, 2014). Interestingly, both discourses emphasize collaboration as a democratic (Long et al., 2006) or equalizing force, in that it requires and results in a flattening of the traditional hierarchy, whether between doctors and other professionals, or between care providers and patients and their families (A. Fox & Reeves, 2014; S. Fox et al., 2021). But what exactly is collaboration?

Definitions of collaboration

Cooperation, coordination, and teamwork are similar terms sometimes considered synonymously with collaboration, sometimes distinguished from it. *Cooperation* has to do with assisting when asked (“Cooperation,” 2022). *Coordination* has to do with fitting together different parts of a working whole, where different contributors attend to what each is doing to know how best to weave in their own contribution to a collective effort (see Strauss, 1988). Teamwork is most similar to collaboration and is sometimes considered under the umbrella of collaboration (e.g., Kitto et al., 2011) but it is not necessary to be part of a team to collaborate.

So, what then is collaboration? A recurring theme is the notion of working together. Etymologically, the word in English stems from the Latin *collaborare* or “to labour with.” The Cambridge Dictionary (2022) provides three definitions of collaboration: (a) It is the situation of two or more people working together to create or achieve the same thing; (b) it is the situation of people working with an enemy who has taken control of their country (I would add that this treasonous sense of collaboration is not limited to control of country but can be invoked anytime a collaboration seems to breach shared notions of identity and territory; and (c) it is the act of working together with other people or organizations to create or achieve something.

In these definitions, there is a nuanced difference in emphasis between “the situation” and “the act,” which is apparent as well in more disciplinary literatures. For instance, in management literature, collaboration is often seen as *structural*, referenced with regard to *inter-organizational* collaboration (e.g., Castañer & Oliveira, 2020). The interdependence of col-

laborators is thought to be written into structures such as role definitions and procedural agreements; focus is on *the situation* in which collaboration takes place, on its inputs and outcomes, yet communication is taken as a given or black-boxed.

In health care, collaboration is understood as both a situation and as acts that are concretized in practice, in particular in practice guidelines on how to collaborate. The World Health Organization (2010) explains that interprofessional collaborative practice happens when health workers from different professions work together to provide comprehensive care to patients across a variety of settings. Much of the literature on interprofessional collaboration tends to be focused on collaborative effectiveness (Buljac-Samardzic et al., 2010; Lemieux-Charles & McGuire, 2006) and its determinants, such as role awareness, trust, shared mental models, and good communication (e.g., San Martín-Rodríguez et al., 2005). Which brings me to our discipline.

Communication scholars are most likely to think of collaboration as *an interactive process* (see Lewis, 2006). Organizational communication scholar Keyton (2017) offers this disciplinary definition of collaboration: “A collaboration is a type of interaction in which individuals, a team or organizational members work together to reach a common shared goal, activity, or production” (p. 1). This definition focuses on *the act* of collaboration, or collaboration as a process. Keyton (2017) further specifies there are 4 requirements for an interaction to be labelled a collaboration: (a) There must be two or more parties interacting around (b) a shared goal or activity (even the mutual achievement of individual goals) and (c) with some degree of interdependence, and (d) the interaction process occurs over some time interval.

Thus, collaboration is a situated process; it can evolve over time but will always be influenced by contextual factors. The goal orientation means that *measures of effectiveness* are the preoccupation of many organizational stakeholders: An effective collaboration is thought to be one where the mutual goal is accomplished by collaborating parties (e.g., Koschmann et al., 2010; Merkeley & Fraser, 2008). This brings me to my second provocative question.

What is Communication's Role in Collaboration?

Outside the discipline of communication, most people will affirm without hesitation, "You need good communication for good collaboration." This common-sense understanding concurs with the social constructionist view of communication as constitutive of collaboration, but what do we mean by good communication and good collaboration? Our answers inform what we pay attention to and where we devote energy and resources. A goal orientation means that "good" collaboration is most often understood as "effective" collaboration, which influences how stakeholders understand the role of communication. So, I will discuss two common goals of collaborative interaction: the timely exchange of information and multivocality. I will also discuss the related issues of power, identity, and relationality.

Timely exchange of information

Unsurprisingly, a functionalist view of collaboration translates to a functionalist view of communication. Typically, in healthcare organizations, effective communication in collaboration is understood as getting the right information to the right people at the right time so

that patient care goals can be accomplished in a safe and timely manner. This view is obviously based on the classic transmission model of communication: Efforts are deployed to reduce barriers or "noise" to the smooth flow of information (Shannon & Weaver, 1949).

For instance, a shared goal in a hospital might be to reduce wait times in the Emergency Department (ED). Clear quantitative indicators include the number of patients in the ED and how long they have to wait to be seen or admitted. Wait times increase when there are no beds in other hospital wards to which patients can be admitted, so it is thought ED wait times can be reduced through rapid and mindful management of patient flow in the hospital, where open beds from other wards allow ED patients to be placed elsewhere.

Thus, each unit manager must be aware of patient flow in their unit and know when patients will leave so they can communicate to the ED manager the number of open beds and the level of care they can provide. Each unit manager also needs a smooth flow of information from their bedside nurses to know what is going on. Hence, it is easy to understand the appeal of viewing communication as the timely transmission of important information, and collaboration is understood here as coordination.

However, this slick depiction of how information circulates between managers hides how it can take place. In the hospital where I collected data, there was a daily ED "bed meeting" attended by all unit managers, where bed availability and anticipated care needs were shared; in theory, a perfect occasion for a smooth flow of information. However, these meetings seemed much more like a messy marketplace of competing interests, where managers sometimes haggled with each other, sometimes accused

each other of withholding bed information to keep their unit's workload manageable. Therefore, missing from the information transmission model are issues of politics and power, among other things. So, this is one area where a constructionist or a critical paradigm can be enlightening.

Power

Power is a common theme in constructionist communication research on collaboration (Keyton, 2017; Lewis, 2006). I define power broadly as the ability to influence a collaboration, whether through access to resources, the ability to shape meaning, (Mumby, 2013), formal or informal authority or status that is negotiated in interaction, for instance through markers of epistemic authority (Benoit Barné & Fox, 2017).

It is rare not to have a difference in power or status among collaborators, especially in organizational contexts. Indeed, Montreal School founders Jim Taylor and Elizabeth Van Every (2000; see also Labov & Fanshel, 1977) proposed that organizational communicators are almost always in a head-complement relationship that confers differential status to them through asymmetrical and complementary roles. An obvious example of a head-complement relationship would be supervisor-supervisee, or in healthcare, doctor-nurse. Thus, as collaborators interact in relation to some shared concern, they continually attend to and negotiate their roles and relative status (S. Fox & Jahn, 2022).

Yet, such differences are often seen as challenges to overcome for effective collaboration because it evidently requires a flat and equal playing field. This can occur through a temporary

flattening of a traditional hierarchy, perhaps manifesting in interaction through inclusive pronouns such as “we” or through intentionally sharing the conversational floor with a lower status member (S. Fox & Comeau-Vallée, 2020).

Another example is SBAR, an interactional protocol designed by the U.S. military for nuclear submarine safety. It is often adopted in healthcare organizations to promote patient safety by facilitating the accurate transfer of important information and allowing nurses and other professionals to be heard when communicating with physicians. SBAR stands for how health professionals should structure their communication when interacting with other collaborators:

- Situation (concise statement of the problem)
- Background (pertinent and brief information related to the situation)
- Assessment (analysis and consideration of options)
- Recommendation (action requested or recommended). (Monsees et al., 2019)

This is a functionalist tool because the interactional script intends to diminish the “noise” of different professional communication styles. The script is similar to how medical residents are trained to speak when they are giving report to supervisors, and learn that being succinct is a prized communication skill for physicians. In contrast, nurses are trained in narrative and non-verbal communication, in which they are encouraged to holistically listen to and consider all aspects of the patient's story. My point is that SBAR invites nurses and other professionals to “talk like a doctor” when they are talking to a doctor, and I think this speaks volumes about power differentials in interprofessional collaboration.

In fact, “talking like a doctor” was an emergent theme in a study my colleagues and I did on nurse practitioners (NPs) integrating into primary care clinics in Quebec (S. Fox et al., 2022). NPs are highly trained, with the legal and clinical authority to make certain diagnoses, prescribe medications, order diagnostic tests, and so on—things that registered and practical nurses can’t necessarily do. Thus, NPs have an expanded scope of professional practice that overlaps and sometimes infringes on the physicians’ scope of practice, depending on their jurisdiction. Often, NPs are integrated into healthcare organizations when there is a shortage of family physicians.

In Quebec, although they are autonomous professionals, NPs must be partnered and supervised with physicians in their clinic. This means they must frequently communicate with their physician partners. One source of friction we found in their interactions is the need to talk like a doctor. Some physicians interviewed complained about NPs who had not learned this, taking too long to get to the point. Their goal of collaborative interaction was the effective and fast exchange of information, but a critical eye can easily discern that it is only one group of professionals who must make such communicative accommodations to the other. And it really bothered some NPs who felt unappreciated and subordinate as teammates.

Identity

“Identity matters because identity creates a filter through which members communicate in the collaboration” (Keyton, 2017, p. 2). When we collaborate, some interests are included in our collaborative interaction and others are excluded, which can create identity tensions. This is especially true when collaborators hail from

different groups, whether countries, organizations, or professions. Yet, complex, intractable problems require just this kind of crossing borders and boundaries—that’s why collaboration is hailed as a remedy to complexity. Thus, identity and collaboration will always be intertwined. With regard to the nurse practitioners I just mentioned, learning to talk like a doctor was also learning to enact a different professional identity in their interactions, and functionalist tools like SBAR just do not encompass this dimension of collaborative interaction.

Moreover, we can recall that collaboration can involve working with the enemy! Interprofessional collaboration has at times been referred to as a turf war between the professions (e.g., Gum et al., 2012; Suter et al., 2009). In our study, it seemed that some physicians indeed felt they were being asked to work with the enemy, or at least with an occupational group trying to encroach on their territory. Many refused to supervise NPs because it would take time away from the number of patients they could see.

NPs said one barrier to their integration on teams was physicians being unaware of their professional roles. This is echoed in the literature on IP collaboration, where role awareness is identified as a determinant for effectiveness (Suter et al., 2009) along with shared mental models (Boreham, 2007; Courtenay et al., 2013). From this perspective, collaboration can be more effective by ensuring everyone understands others’ professional roles and ways of thinking, prior to interacting.

While this may be true, this individualistic, cognitive view does not attend to what happens in collaborative interaction, which obscures how communication and collaboration are imbricated (Careau et al., 2014). Understanding what happens (or not) in collaborative interac-

tion can influence how professional schedules are structured, how the built environment is designed (Dean et al., 2016), and how students in the health professions are trained. These are areas where constructionist communication scholars can make practical contributions.

In this vein, the IECEP (2011), a group of experts from the professional orders and associations in the U.S., proposed that communication is a competency each student in the health professions needs to master as preparation for IP practice (see also, Suter et al., 2009). By focusing on “how to communicate,” the expert panel implicitly recognized communication as doing more than transmitting information, because a stated goal of competent IP communication practices is enhancing team functioning and team relations through common understanding and ensuring all voices are heard. In other words, the panel recognized that how interaction unfolds makes a difference to team climate and a sense of inclusion. Thus, this depiction begins to align with a constructionist view of communication as constituting collaborative practice.

This paradigmatic alignment is an opportunity for engaged constructionist communication scholars to dialogue with policy and decision-makers around setting IP curricula, such as empirically demonstrating how communicative competence is a collective phenomenon negotiated in interaction (e.g., Horila, 2019). This collectively negotiated nature is especially true with regard to multivocality, another yardstick often used to evaluate good or effective collaboration.

Multivocality

Collaborative effectiveness is often thought to hinge on multivocality: All stakeholders voices who should be heard can be heard (Long et al., 2006), a main reason why efforts are deployed to flatten the hierarchy or to equalize status differences. In one study, we found that multivocality in collaborative interactions is especially important for three types of collaboration (S. Fox et al., 2019). First is coordinating sequential yet distinct efforts so everyone knows what everyone else is doing and can weave in their own contributions accordingly. For instance, when coordinating a patient’s hospital discharge, complex cases are governed by a checklist to ensure all is in place so the patient doesn’t end up back in the ED shortly after being discharged, which is a sign of ineffective collaboration. Second is assisting others to make sense what is going on, for instance, interpreting professional jargon for those outside one’s profession. An example is pharmacists who review and synthesize the pharmaceutical component of a patient’s medical history so physicians can easily understand it. Finally, and probably most importantly, is shared sensemaking and shared decision making (S. Fox & Brummans, 2019; Opie, 2000). When problems are very complex or uncertain, multivocality is necessary to gain a holistic view of the situation and what can be done about it. This is the holy grail of IP collaborative interaction.

In each of these instances, communication is understood as doing far more than just transmitting information; it is understood as constitutive because the notion of effectiveness is based on collaborative process. Communication is understood as central to the very work of collaboration, whether this is coordination of different contributions, interpretation of professional jargon, or collectively making sense of

what is going on and coming up with action plans. Hence, multivocality must be built into the process of communicating about complex problems.

Relationality and Team Care

Collaborative process also really matters when it comes to relationality. At the level of lived experience, how we communicate in collaboration plays a big role in team climate, in fostering a sense of inclusion or exclusion, and in collaborative well-being. This tends to be overlooked in much collaboration literature because it is so rationally task- and goal-oriented. An exception is the view of trust as key to collaborative effectiveness (Buljac-Samardzic et al., 2010; San Martín-Rodríguez et al., 2005). However, the benefits of trust go beyond increasing synergy among collaborators, which ostensibly leads to better team performance. Trust attests to a level of vulnerability that is necessary for what Kirstie McAllum and I are calling “team care.”

My thoughts on relationality, team care, and communication are still preliminary because we are collecting data for a study on collaboration experiences during the pandemic in residential long-term care facilities for older adults in Quebec. We are investigating what it was like to collaborate during this time, when fear and uncertainty were high, systems were failing, and the army was literally called in to help. These are obviously extreme circumstances in which to collaborate, and workers suffered from moral distress, compassion fatigue, burnout, and other things, and there is a lot of talk about how to boost health workers’ resilience (DeBoer et al., 2021; Matheson et al., 2016).

However, resilience is far too often conceptualized as an individual capacity (Aburn et

al., 2020), placing responsibility for well-being on the stressed-out worker, who might be encouraged to call an organizational help line (Hewison et al., 2019) or meditate and do some yoga. Therefore, we propose resilience must be conceived both as collective (i.e., team resilience) and as something that emerges from and is sustained by compassionate collaborative interaction. Our scoping review of the literature (forthcoming) identifies several communicative practices that manifest team care. For instance, relational maintenance happens by making sure collaborators feel seen and valued, fostering their sense of belonging through acts of kindness. Another socially supportive communicative practice is sharing one’s feelings of distress with collaborators and encouraging them to share as well; here, the very act of communicating is therapeutic, and this is where the space and safety to be vulnerable is so essential.

Nevertheless, creating such space and safety to support team resilience and relationality is challenging because it takes resources, like time. But as we all know, our healthcare systems—especially public healthcare systems—have been increasingly permeated with quality improvement initiatives like Lean healthcare (e.g., McGough et al., 2017), whose goal is to “trim the fat” as much as possible to streamline and enhance effectiveness. As a result, we find our healthcare systems emaciated in the third year of this pandemic. The trimmed fat is not only people (so the solution is not only to hire more professionals like nurses), but also what I would call “fat time”—time for connecting, socializing, and supporting—as part of collaborative practice. This means that notions of collaborative and communicative effectiveness ought to encompass these elements of relationality and temporality; perhaps constructionist research can help here.

What Implications Follow?

What follows from our understanding of collaboration and the role of communication, and especially our awareness of the paradigmatic tension between functionalist and constructionist conceptions of these two intertwined phenomena? How can we get beyond the dismissive response from functionalists, with whom engaged constructionist communication scholars might do research, that our findings are “nice to know” without overly simplifying? I don’t presume to have definitive answers, or even that such answers exist, but I can offer three lessons learned.

The first lesson I wish I had learned for doing engaged constructionist research in functionalist organizations is to learn the language that organizational stakeholders and decision makers use. In healthcare, this often means learning and using the jargon of quality improvement. It entails explaining why collaborative *interaction* matters and contextualizing this importance with regard to other organizational goals. This inevitably means bridging two worlds, and it is not always easy: You might feel like you are trying to paddle two kayaks standing up!

Second, when you learn their language, their preoccupations, and how they talk about them, you can look for areas of alignment with a constructionist perspective and target your efforts at dialogue there. For instance, “learning” or “training” can be key words indicating an area of alignment because they imply processes of interpretation, socialization, and appropriation where communication is observably constitutive. Similarly, the prefixes “cross” and “inter,” as in intercultural, cross-disciplinary, might indicate opportunities for functionalist-constructionist paradigmatic alignment because they indicate differences in interpretation where a

transmission model is insufficient. Finally, a cheeky lesson I’ve learned: Functionalists love diagrams! (I do too, actually.) A picture that communicates findings is literally worth a thousand words—in an article, a thesis, or dissertation!

To return to my story from the beginning, what would I now say to the physician researcher about the narrative sensemaking practices I discovered? I would frame my findings in terms of quality of patient care and patient safety. One thing I noticed in observing narrative talk about the same patient over the course of a week is that team members can narratively emplot the same events of a patient’s situation and actually tell different stories (see S. Fox & Brummans, 2019). These different stories have consequences for patient care. And then I would ask her about her own experiences and her ideas about how to raise awareness among practitioners about the way they talk about the patient in the clinical backstage. Kiitos paljon!

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OTSIKKO JA AVAINSANAT SUOMEKSI:

Mitä yhteistyö ennakoi: Petollisesta huolenpitoon tiimeinä

AVAINSANAT: yhteistyö, viestintä, terveydenhoito, organisaatioviestintä, tiimit