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Exploring Professional Culture in the Context of Family Health Team Interprofessional Collaboration

Jennifer Beales BA, MA *Faculty of Pharmaceutical Sciences, University of Toronto*

Rishma Walji BSc, ND, PhD *Department of Health, Aging and Society, Faculty of Social Sciences, McMaster University*

Christine Papoushek PharmD *Faculty of Pharmaceutical Sciences, University of Toronto | University Health Network (UHN) Department of Pharmacy & Toronto Western Family Health Team*

Zubin Austin BS Phm, MBA, MIS, PhD *Faculty of Pharmaceutical Sciences, University of Toronto*

Abstract

BACKGROUND While family health teams (FHTs) seek to deliver collaborative patient-centered care, the barriers that can arise due to a practitioner's professional culture pose a challenge to attaining interprofessional collaboration. The effect of professional culture in relation to FHT collaboration has not yet been examined, and a heightened awareness and appreciation of how this concept influences team dynamics holds promise to improve interprofessional collaboration on these and other evolving health care teams.

METHODS Qualitative secondary data analysis was conducted on data collected from in-depth semi-structured focus groups (n=5). A non-random convenience sample consisted of 42 participants from medicine, nursing, and allied health professions at the Family Health Centre and Diabetes Education Centre in a large academic teaching hospital in urban Canada. Discussions were audio-taped and transcribed verbatim. Transcripts were analyzed for themes using a modified directed content analysis approach.

FINDINGS Three main themes emerged: professional culture; FHT culture; and resources. Professional culture cannot be neatly separated from one's personal, social or professional history, which ties in with opinions of accountability, power and hierarchy. Structure and processes of the FHT that encourage collaborative processes; clearly articulated scopes of practice, skills, authority; clarifications of roles and responsibilities; and opportunities to develop team relationships are necessary to diffuse the tension that exists between professional and FHT cultures.

CONCLUSIONS FHTs are multidisciplinary groups co-located but with a lack of meaningful structures and processes to support collaboration. There is heavy physician dominance and physicians seem to adhere to old hierarchical structures and beliefs, consistent with their professional culture. In general, the health care providers need to build collaborative competencies (e.g. role clarity, effective communication) in order to move a group of interdisciplinary health care providers toward being a highly performing interprofessional team.

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Implications for Interprofessional Practice

- Collaboration is more than simply placing people together and hoping they will be able to organically get along and make it happen.
- Health care providers require more experiences that foster interprofessional socialization and evolving team culture.
- Our models of collaboration may need to be reexamined so that we can manage expectations: “knot-working” and situational collaboration may be better models.

Introduction

In an effort to deal with concerns of affordability and sustainability of the Canadian health care system, reports have stressed the importance of interprofessional collaboration in improving patients' quality of care and in effecting change in the health care system (National, 2002; Romanow, 2002). Family health teams have been created in order to make optimal use of existing health care practitioners' knowledge and skills, while government and educational arenas work on diminishing the Health Human Resource shortage (Ontario, 2005). Literature suggests that quality of care can be improved when skills, knowledge, and experience are effectively coordinated between professional groups (Aiken, Sloane, & Sochalski, 1998; S. Reeves & Lewin, 2004; S. Reeves, Lewin, Meyer, & Glynn, 2003; Schmitt, 2001; Sorrells-Jones, 1998; Way, Jones, & Busing, 2000; Zwarenstein, Bryant, Bailie, & Sibthorpe, 1997). Moreover, the interprofessional collaborative ideal in health policy is widely supported in political agendas internationally (Leathard, 2003; Martin, et al., 2004; National, 2002; Romanow, 2002; Willumsen & Breivik, 2003).

In the emerging Canadian paradigm, the cultural shift in health care circles, which advocates patient centeredness, is constructed on the tenet that interprofessional collaboration among health care providers will improve patient care. Culture is defined as the social heritage of a community (Parkes, Laungani, & Young, 1997). Each health care profession has a different culture, including values, beliefs, attitudes, customs, and behaviours

(Schroeder, Morrison, Cavanaugh, West, & Montgomery, 1999). This culture or world view is passed on to the subsequent trainees in the profession, but it remains obscure to other professions (Hall, 2005; Irvine, Kerridge, McPhee, & Freeman, 2002). The effect of professional culture on the success of the interprofessional group, however, is an under-discussed topic in the literature. This paper will highlight the importance and challenges of professional culture on interactions with other professionals.

The Ontario Government has created the Family Health Team (FHT) Initiative, which has established 170 FHTs across Ontario, with plans to fund an additional 30 teams over the next three years (Ontario Newsroom, 2010, August 24; Ontario Newsroom, 2009, December 11). Designed around specific community needs, these teams may consist of doctors, nurse practitioners, and nurses, in addition to chiropractors, rehabilitation workers, social workers, dieticians, pharmacists, physician specialists, and mental health workers (Ontario, 2005, December 9, 2005, July 4; Romanow, 2002). The concept of the FHT is an ideal setting to examine the notion of collaborative patient-centered care and interprofessional collaboration. A FHT is similar to the concept of “medical home,” where responsibility for care and care coordination resides with the patient's personal medical provider working with a health care team (Grumbach & Bodenheimer, 2002; Rosenthal, 2008).

Despite a number of publications that outline best practices in collaborative teamwork, and collaborative environments (EICP, 2005, January; Oandasan, et al., 2004; Way, et al., 2000), minimal research and theory exists about teams whether they operate in a true collaborative fashion. The literature on interprofessional collaboration outlines barriers and challenges when applying the interprofessional collaboration ideal in health care settings. These barriers have (Vyt, 2008; Xyrichis & Lowton, 2008) been identified as follows: individual values; learning about interprofessional differences and respective roles; internalizing a common purpose and goal; creating norms and values that shape social and professional behaviour and activities; trust (Ontario, 2005, July 4); fear of change; different professional agendas (Ontario, 2005, July 4); power imbalances; and the walls of professional identity and territoriality (Oandasan, et al., 2004). These barriers have a shared origin that is the result of professional cultures existing in an interprofessional team setting. While the literature on interprofessional collaboration is expanding, it fails to address how health care professionals possessing diverse professional ideals, or professional world views, will negotiate their roles as developed in their professional culture, and collaborate as a team. The family health team presents an excellent opportunity to study the interplay of professional culture and interprofessional teamwork.

Using a qualitative approach, this study explores the concept of professional culture in a family health team environment. The research questions are: 1. How does

professional culture manifest in the day to day workings of a FHT, and 2. How does professional culture influence interprofessional collaborative patient-centered care in this team based setting.

Methods

This is a secondary analysis of a qualitative data set. Researchers conducted semi-structured focus groups (n=5) as the original data set, to capitalize on the dynamic communication between participants (Kitzinger, 1995). The primary data set was part of an exploratory qualitative study designed to identify and develop a collaborative practice model in managing Type 2 Diabetes. The initial study was designed to explore those factors that health care professionals deemed facilitators or barriers to interprofessional collaboration.

The Family Health Centre (FHC) and Diabetes Education Centre (DEC) at an academic teaching hospital located in urban Ontario were selected. The primary sampling strategy was a non-random convenience sample (Cresswell, 1998). All full and part-time staff physicians, nurses, and allied health care professionals providing patient care at the FHC and the DEC were invited to voluntarily participate in the study. In total, 42 individuals – including pharmacists, registered dietitians, social workers, registered nurses, cognitive behavioral therapists, and nurse practitioners - participated in five focus groups. For a breakdown of the focus groups, see Table 1.

Table 1

Composition of Focus Groups

Focus Group	Number of Physicians	Number of Allied
1	7	0
2	0	9
3	2	6
4	4	2
5	4	8

In order to preserve the confidentiality and anonymity of the focus group participants, participants were assigned identifying labels of “physician” or “allied” (allied health care professional) rather than specifying the particular type of allied health professional.

Five semi-structured focus groups¹ occurred in February and March 2007. The focus groups consisted of 6-12 participants each. Sessions lasted approximately 90 minutes. A semi-structured interview format was used exploring participants' experiences of issues surrounding the delivery of patient-centered care in an interprofessional collaborative working environment. All focus groups were carried out under the guidance of a trained moderator who followed the basic principles for conducting focus groups (Berg, 1998; Krueger, 1994). Using a semi-structured interview guide, participants were asked questions related to interprofessional collaboration. Examples of questions included: (a) how they defined collaboration; (b) how and when team members worked together; (c) what factors restricted their ability to collaborate; and (d) what facilitated their ability to collaborate. The focus groups were audio-taped and transcribed verbatim and detailed handwritten notes were taken.

The primary data were collected to examine a facet of the interprofessional collaborative process. Accordingly, this secondary analysis of the data, to examine professional culture in the context of interprofessional collaboration, was tangential to the original purpose of the data collection process. The data were coded, and key emerging themes were identified using content analysis (Hsieh & Shannon, 2005). An integrative approach was used where an organizational framework was developed first and these preliminary codes enabled the researchers to integrate concepts already known in the literature. Links were developed among conceptual codes and participant perspectives and professions were characterized to help develop themes (Lincoln & Guba, 1985; Miles & Huberman, 1994). Two researchers confirmed the themes from the original data set and discrepancies were discussed until consensus was reached. In addition, field notes were taken during the original data set collection and used in the secondary data analysis. Data were entered, organized, and coded in QSR International's

Nvivo 7 (NVivo qualitative data analysis software, 2006). Data were analyzed using a content analysis approach (Hsieh & Shannon, 2005; Miller, et al., 2008) that utilized sensitizing concepts to guide the coding process (Bowen, 2006; Charmaz, 2003; Patton, 1990).

Ethics approval was provided by the hospital where the study was conducted, and focus group participants provided written informed consent. All transcripts and field notes were anonymized and purged of all identifying characteristics.

Results

Analysis of the transcripts highlighted three domains that reflected professional culture in the context of an FHT: professional culture, FHT culture, and resources. Within each domain, major sub-themes emerged which are discussed below.

Professional Culture

Analysis of the focus group transcripts brought to light three major themes from which professional culture was evidenced among participants: professional hierarchy, accountability, and power relations.

Professional Hierarchy

The recognition of a distinct professional hierarchy on the FHT emerged strongly in all focus groups, and these hierarchal perceptions create tension among the practicing health care professionals.

I think that if a physician says something to me, I, it wouldn't enter my mind to say "you're sort of overstepping your role or you are sort of outside of your practice" um, but if some other professional said something to me, somehow that comes into that equation (Physician1-FG5).

¹The first two focus groups were homogeneous groups (Group 1- physicians only; and Group 2- allied health care professionals only). The next three focus groups were heterogeneous groups. The homogenous focus groups provided the participants an opportunity to be open about their attitudes, experiences, opinions, and beliefs amongst their peers without feeling influenced by perceived power structures. The heterogeneous groups provided the participants an opportunity to share experiences, ideas, and opinions and brainstorm together in a 'synergistic' forum. These two types of groups enabled the researchers to collect a range of perceptions that may not have been elicited from using homogenous or heterogeneous groups alone.

Some physicians are more willing to share their power with other members of the team, where others really feel that they need to maintain control and they see other team members as being, um, no - not subservient because that is the wrong word, but as being underneath - that they are supervising other members of the team (Allied2-FG2).

The professional hierarchy is internalized by both physicians and allied health care professionals alike. Most allied health care professionals perceive a professional hierarchy that obliges them to defer to the physician's authority.

Accountability

Joint responsibility and shared decision-making among FHT members calls for health care professionals to be responsible for varying degrees of patient care as they relate to scopes of practice. While focus group participants are part of an FHT that supports the mandate of interprofessional collaboration and have been provided with some opportunities to begin internalizing an FHT world view that supports egalitarian relationships, this cultural shift has yet to be realized.

You get socialized in medical school to become the responsible one, and I think that this is changing, but, for example, if I pick nursing as an example, they are cultured to say that the physician is the one who is responsible. So it is interesting because they defer and we accept (Physician7-FG1).

For physicians, the tension and confusion surrounding what they perceive to be the hesitancy of allied health care professionals taking on more responsibility in the delivery of patient care, related to the perceived hierarchical relations on the health care team:

We dance around the diplomatic roles of not offending the physician or saying things that they might find offensive or change ownership, and to me that is a reflection of limitations of authority... that people think that they have to act in a certain way in order to engage the physician... and it is that hierarchy that I think is the major barrier (Physician1-FG5).

Most participants agreed that for this change to take place, the FHT would have to clearly define who is responsible for what:

I mean we all have scopes of practice that we have to abide by, and I think that when there are overlapping responsibilities and accountabilities then the important thing is that those need to be clearly articulated. So whether that is your creation of policies or guidelines, but those need to be there so that if there is ambiguity, there is an agreed upon document or policy that people can go to and say that "this is what we decided as a team, and so this is how and why we do things this way," and so most of the documents won't say it is going to be the physician's responsibility for everything, it will probably be the shared responsibility. I think where the discomfort comes in is that it is not clearly articulated, so we are not really sure and we always default to the physician - and where they are most responsible is their accountability (Allied6-FG2).

Along these lines, all health care professionals must be willing to accept equal degrees of responsibility and share all issues related to patient care.

I don't like the term gatekeeper, but we were on the hook, and I think that at the present time we are still on the hook. And you know when a lab test, like last night I get phoned about an urgent lab test and I was the one who was phoned and not members of the team. It was me - and that still persists (Phys2-FG1).

Well, they [physicians] are the ones who sign on the bottom line, and it may be the pharmacist who fills it out and says 'hey' and calls them back and says it is wrong, but I still think that most of the responsibility is still on the physician. That is how I feel (Phys3-FG1).

While participants recognized that a change is on the horizon, uncertainties surrounding professional responsibilities and accountabilities constitute real barriers to successful collaboration. Physicians commented on the fact that qualities of professional accountability and responsibility guide their work, whereas other team members do not embrace these qualities to the same degree, especially when confronted with a medical challenge/dilemma. Allied health care professionals may defer to physicians because there is uncertainty surrounding responsibility. When in doubt, the physician is the most likely to be accountable.

Just on the issue of accountability - when everything goes well it is 'our patient,' when things go sour it is 'your patient.' That is what I hear, and that is what I am talking about. And I think the teams should be prepared to say that it is still 'our patient' when things are not going well (Physician2-FG1).

Power Relations

The power struggle associated with taking leadership of a team or ownership of patient care is another issue that arises in team-based practice, particularly with physicians taking the leadership position. The notion of collaboration on the other hand, requires distribution of responsibilities and trust in other team members.

Allied health care professionals acknowledge that physicians have traditionally held the power in medicine, but concede that all team members must be prepared to take on more:

I would say that normally the physician has been the gatekeeper and the holder of power, and more of a one on one. So there has to be a willingness of all of the partners on the team to share the power, I think (Allied2-FG2).

I think it makes a big difference on leadership and if you are willing to rise and be willing to take the challenge of learning something new, um and incorporate that into your practice. Ah, I think the flip side of that is some people get bogged down by being 'the expert' or the one that everyone comes to instead of spreading it around (Allied1-FG2).

Allied health care professionals recognized physicians' sense of patient ownership, which they perceived to be a barrier to collaborating:

I see the physicians not wanting to share, and there are certain physicians who will hold on to 'my patient,' and don't want to have anyone else involved (Allied4-FG2).

Most of the time when people behave in certain ways is because they feel threatened, so if you acknowledge that yes, this is your thing and bring the patients that I feel would benefit from that strength of that person, ... [and think] "I don't feel threatened by that person"... (Allied3-FG2).

While being socialized and trained into the culture of a profession, health care professionals internalize professional responsibilities and values that reflect the larger mandate of their profession. In medicine, one of the most profound values is that of the doctor-patient relationship. As health care settings evolve toward shared care, this central relationship could potentially be lost as other health care professionals forge relationships with the patient. This concern was echoed by physicians:

One of the principles of family medicine is the relationship that you have with the patient. Do we jeopardize that in some way with collaborative practice? What keeps me hooked into the patient? (Physician2-FG1).

We talk about ownership and the patients feel like they own you and you own them, and it is 'MY PATIENT!' I am going to go see 'my patients' and you sort of develop that relationship and that needs... it is a culture change that is a big barrier, and it is very hard to go through that frame of mind (Physician7-FG1).

This notion of power and control is directly related to whose skill sets are perceived to be valued more. In this light, it appears that some professionals may pay lip service to the ideals of interprofessional collaboration and support it abstractly, but in reality there are certain times when they may feel exempted from working collectively as a team. Physicians will often naturally assume a leadership role and are expected to be accountable for the patient outcomes:

[I]n some places the quarterback needs to run with the ball, and he just has to do it himself (Physician3-FG1).

FHT Culture

In virtually all focus groups, participants identified the manner in which professional culture was impinged upon by the FHT culture. Elements of FHT culture include: FHT environment; and understanding roles and capabilities.

FHT Environment

Participants acknowledged that the FHT environment

outwardly recognized and supported the mandate of interprofessional collaboration. As an organization, the FHT had hired a variety of health care professionals with complementary skill sets and practices who were expected to work together as a team.

Being associated with an academic teaching hospital had exposed them to continuing education sessions and various team-building initiatives. One physician recognized the importance of having a complementary array of skill sets on the team:

You tap skill sets that are not available in other disciplines. For example, an occupational therapist may have knowledge that physicians don't regarding functional abilities, and physicians historically are the quarterback - as far as they are the only ones who write orders in the hospital chart, and we are moving and we are changing, but certainly we are tapping knowledge that physicians don't have (Physician3-FG1).

The real life experiences modeling interprofessional collaboration, while limited, were enthusiastically supported by professionals. Participants in the study frequently referred to these opportunities as being rewarding, valued, and appreciated among team members. For most participants, these infrequent occasions presented them a chance to become acquainted with the roles and scopes of practice of other team members. One physician shared his recent experience with a pilot program, championing the learning potential when health care professionals adopt a synergistic approach to patient care:

We have just started this initiative of doing an interprofessional rapid consult where people could come with the patient and go through an hour and a half, or two hour session, and as I did in the first day learn more about insulin distribution systems or dietary records or things in an hour and a half that I couldn't have learned otherwise in many other forums (Physician1-FG5).

Despite the efforts, participants commented that the environment does not facilitate collaboration given that the FHT has a revolving door of learners, which makes relationship-building and understanding of roles and responsibilities that much more challenging:

It is very hard to have collaborative patient care that is good if people are only in the office half a day a week, and I am going to put that out 'that you have to be around to do this' (Physician2-FG3).

Once you go and have turnover of team members, that speaks to the sustainability of healthy teams, and you never know who is going to be that person in the office two [doors] down from you - who is supposed to be doing that role? Who is in your space every two to three years? How does an effective team continue to function? (Physician6-FG1).

In addition to the turnover of learners who are present on the FHT for a finite amount of hours per week, there are other health care professionals whose term is limited on the FHT. Participants in this study frequently spoke of their frustration of not being able to contact or find a particular health care professional who only worked two or three days per week. Consequently, while FHTs have attempted to create an environment that fosters the interprofessional collaboration ideal, in practice it did not support a collaborative culture.

Understanding Roles and Capabilities

Participants commented on the fact that collaborative meetings to discuss patient care were not a regular occurrence on the FHT. Moreover, there had been no designated clinic time to learn individual roles, competencies, or skill sets.

I think for this to work, the practice will be for all of us to get to understand the roles and capabilities of each other and that will be work, and only when those barriers are overcome will we be able to change the culture (Physician8-FG1).

For many participants the need for understanding roles and scopes of practice, in addition to clarifying who is responsible for what, was deemed not only important but essential:

There has to be time devoted to clinic time together and understanding each other's roles and getting that comfort level and that somehow needs to be built in (Physician2-FG5).

Despite the fact that this FHT was affiliated with an academic teaching hospital (which is indicative of a high-

ly functioning complement of academically-inclined health care professionals), and that FHT members were exposed to various collaborative practice learning opportunities, participants were not necessarily aware of each other's roles:

I think the other piece is how much do we know? I actually can say honestly I don't know your scope of practice... in order to define that we need to have an opportunity to dialogue and really know (Physician1-FG3).

Participants repeatedly spoke of the lack of designated time to learn roles and scopes of practice, which hindered their ability to successfully collaborate. Moreover, they were of the opinion that the FHT required a coordinated approach and formal definition that clearly set out who was responsible for what, as well as the various skill sets:

We all have scopes of practice that we have to abide by, and I think that if there are overlapping responsibilities and accountabilities then the important thing is that those need to be clearly articulated. So whether that is your creation of policies or guidelines, but those need to be there so that if there is uncertainty - there is an agreed upon document or policy that people can go to (Allied6-FG2).

I think it has to be a coordinated, conscious effort. I don't think that you can just put a bunch of people together and expect them to work the best. It has to be facilitated and there has to be time set aside, and there have to be opportunities for people to get to know other peoples' roles and voice their thoughts on how inefficiencies can be improved. It doesn't just happen, to be efficient (Allied6-FG2).

As the FHT lacked an effective process in conveying roles and scopes of practice, this impinged upon health care professionals' abilities to communicate and collaborate with one another.

Resources

Lastly, resources were identified as having the propensity to create tension among FHT members. Resource utilization impinged upon FHT culture and professional culture, and shaped how health care professionals viewed collaboration. The main resource of contention

was monetary compensation.

Compensation Tension

Tension was evidenced in the data as participants discussed the fee structure of the varying health care professions on the FHT, and the manner in which they were compensated. Both physicians and allied health care professionals explained that the manner in which physicians are paid poses a limitation to fostering a collaborative culture on the FHT. Consequently, physicians remove themselves from the FHT culture and are more likely to retreat to the comfort zone of their professional world view where they are rewarded for patient care rather than collaboration.

Some of it has to do with sharing of responsibility and the fee structure and how that works, and that is the big barrier that we did not talk about. But when physicians have to bill to earn their money, that does impact us (Allied2-FG2).

I think money is the barrier - that our current system of rewarding team members is a barrier (Allied1-FG5).

Part of my biggest frustration with being a physician is that idea that you spend time on the phone, and go to team meetings, and talk about patients... everyone who is there, excuse me for that, but the majority of you [allied health care professionals] on salary - that is all part of your day, but it is NOT part of mine. So I am taking time off where I am not actually earning income and where my expenses are going to attend that (Physician2-FG5).

Most allied health care professionals commented on the fact that they perceived compensation to be a barrier to collaboration and explained that because physicians had to bill to earn their money, it was less likely that they would voluntarily participate in interprofessional collaboration meetings. On a larger level, this distinction in how FHT professionals are compensated transmits a silent message throughout the team that the FHT, as an organization, does not value all health care professionals in the same manner – contrary to what the culture advocates.

Physicians recognize a value attached to providing direct patient care and feel their time should be similarly

rewarded when being present for, or participating in, team-building initiatives or indirect care. This distinction of being different from other members of the team also fails to support the equal-status basis requisite for successful and integrated collaboration.

Discussion

While participants in this study were well-versed in what interprofessional collaboration was and how it should play out on the team, FHT members were still unsure of who was competent, had authority, and could provide assistance when needed. Moreover, they acknowledged that a cultural change had not been seen on the FHT. It still functioned in a hierarchal manner with physicians holding the greatest responsibility and making decisions when they saw fit. Physicians' professional training embeds concepts of power, authority, and hierarchy in the identities of many health care professionals: This professional hierarchy is further sustained when the environment and clarification of roles in the FHT operating system have not been clearly established. It is noted that each theme and ideas therein are interwoven with other themes. Professional culture cannot be neatly separated from one's personal, social, or professional history for example and this ties in with opinions of accountability, power and hierarchy. Even though health care professionals had adopted definitions and ideas that suggest they support the interprofessional collaboration ideal, their FHT frames of reference have not been fully developed to the point where they can call upon them to make sense of their work environments in the face of uncertainty. This causes them to fall back on their previous professional culture (where their frames of reference are fully developed) to enable them to make sense of their surroundings through their uni-professional lens.

According to Bloor and Dawson (1994), when conflict and uncertainty are present within organizational culture, the individual's professional culture emerges. In the present research, in a FHT environment, it was found that during conflict or unclear team dynamics, health care professionals abandon their evolving FHT world views and re-engage their own professional world views as a way of making sense of the particular situation. Consequently, professional dominance and professional hierarchies are perpetuated, maintained, and reinforced. The experience of discomfort triggers professionals to retreat to the safe zone of their earlier frames of reference (their professional culture) which

imparted notions regarding professional dominance and hierarchy. A retreat by health care professionals to this perception, is where they switch from their FHT culture into their professional culture, allowing them to comfortably coexist with and understand the other members of the FHT. In this way, the individual's professional culture is seemingly stronger than that of his/her developing FHT culture. Health care professionals need enough interprofessional collaborative experiences to be able to develop their FHT culture. In addition, the FHT needs established structures or processes that clearly define who does what and who is responsible for what. Additionally, in order to function effectively, it is necessary to fully articulate the various scopes of practice among team members, in order to allow individual health care providers to move from inherent, distinct professional cultures and move toward the new model of unified FHT culture.

Interestingly, the make-up of participants in the individual focus groups influenced the overall direction and tone of the discussions that transpired. In particular, it was noticeable that the majority of the quotes came from focus groups 1 and 2, both of which only included either physicians or allied health care providers, but not both. The discussions were more limited in the mixed groups and focused on processes within the team as opposed to interaction with other providers, which was more defined in the homogenous groups. This is a related notable aspect to the overall professional culture and domains and themes that were identified through this research.

While other health care professions' (i.e., nursing and pharmacy) training environments cultivate learning to work as a team, communication, and sharing, medicine is one that imparts independence, and competition (Austin, Gregory & Martin, 2007; Hall, 2005). In this way, nurses and pharmacists may have less difficulty internalizing FHT culture as it maps clearly onto their previous professional frames of reference. Physicians may have a harder time doing this, and accordingly hold steadfast to their medical frame of reference which imparts dominance, responsibility, self confidence, independence, and competition (Austin, et al., 2007; Hall, 2005).

In order to prevent health care professionals from retreating to their safe zones, their own professional culture, the structure and processes of the FHT must not only endorse but implement mechanisms and clear methods

enabling collaborative culture. Examples of these practices include but are not limited to implementing team development meetings; generating formalized protocols that clearly articulate scopes of practice, skills, authority; clarifying who does what and who takes responsibility; and providing opportunities to develop team relationships that foster trust and mutual understanding of fellow team members' competencies, skills, and cultures. If implementation of these types of activities can be successfully accomplished, the tension that exists between professional and FHT cultures may be lessened and the interprofessional collaboration ideal may be more fully adopted.

Limitations

A common limitation with secondary analysis of data is the reality that the data was originally collected in service of answering a different question or hypothesis. Therefore, when performing secondary analysis, the quality and trustworthiness of that analysis are based on the availability of the original transcripts and the participation of a researcher who was integrally involved in the original study (Heaton, 2004). In this instance, the authors had access to knowledge about the context in which the data were collected, which helped to inform the secondary analysis. Another important factor in establishing quality was that the new research question not only fit with the original data but arose directly from the primary data (Thorne, 1994). To attain unbiased results, an audit trail was used during data analysis to track the progression of the coding frame and the evolution of coding categories (Hsieh & Shannon, 2005).

Beyond methodological considerations, this research is primarily limited by the fact that the study focused on professionals working at one FHT and therefore participants represent one FHT, in one geographical location. Nonetheless, tension among the health care professions arose repeatedly in each focus group discussion, reflecting tangible issues that are faced by FHT members in the provision of collaborative patient-centered care. Accordingly, this study provides a depth of understanding to professional cultures and FHT culture and generates themes that might be applicable in a broader context. Second, the study was constrained by the parameters of the original primary study. Third, the data clearly identify the cultural differences and similarities between the "physician" and that of "allied" groups. In order to preserve the confidentiality and anonymity of the focus

group participants, these participants were assigned labels of "physician" or "allied" (allied health care professional) which ultimately limited interpretation of the data, as these identifiers did not fully capture nor adequately reflect the true diversity of professional cultures found on the FHT. However, it is recognized that the similarities and differences among the different health care professionals subsumed under the 'allied' group are undoubtedly correspondingly distinct. Finally, this study does not place variables of social significance such as race, class, ethnicity, and gender under a lens. These variables constitute additional overlapping social identities that health care professionals must negotiate and these, too, ultimately inform their overall world views. To this end, while certainly not exhaustive, this study lays the groundwork for tomorrow's research on professional culture in the context of interprofessional collaboration and evolving FHT culture. Moreover, the themes establish a basis for further research.

Conclusion

This paper offers fresh insight into the concept of professional culture and evolving FHT culture and does so in the context of interprofessional collaboration. This research provides an initial lens through which one may begin to conceptualize how diverse professional cultures will respond to this wider cultural shift in the delivery of health care. While professional culture has been identified as a barrier to interprofessional collaboration in the literature, with a better understanding of how professional culture shapes and is shaped by FHT culture, educators, institutional leaders, government officials, hospital leaders, and practitioners will be better-equipped to develop, support, and sustain the interprofessional collaboration ideal in the context of providing patient-centered care.

Abbreviations

FHT – family health team

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Corresponding Author

Zubin Austin BScPhm, MBA, MIS, PhD
Associate Professor

Leslie Dan Faculty of Pharmacy
University of Toronto
144 College Street
Toronto, Ontario, Canada M5S 3M2

zubin.austin@utoronto.ca