

The Phenomenon of Collaboration: A Phenomenologic Study of Collaboration between Family Medicine and Obstetrics and Gynecology Departments at an Academic Medical Center

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Collaboration is essential to manage complex real world problems. We used phenomenologic methods to elaborate a description of collaboration between two departments at an academic medical center who considered their relationship to represent a model of effective collaboration. Key collaborative structures included a shared vision and commitment by leaders, rigorous quality improvement, clear delineation of roles with built-in flexibility, ongoing commitment to formal and informal communication channels and conflict resolution, relationship development grounded in respect and responsiveness, and shared training in a supportive learning environment with legitimate participation fostering skill development. This study reveals the complexity and resources required for collaboration which both explains why collaboration is not as easy to achieve and identifies processes that foster collaboration. Key Words: Collaboration, Phenomenology, Family Medicine, and Obstetrics

There is a growing recognition that complex health issues necessitate intersectoral collaboration among medical specialties and with others outside of medicine. Collaboration in health care is cited as essential by national professional organizations (American College of Physicians, 2006; Future of Family Medicine Project Leadership Committee, 2004; Institute of Medicine, 2001; Lefebvre, 2007) and is a necessary component of Community Oriented Primary Health Care (Gottlieb, 2009) and the Patient Centered Medical Home that is promoted as a key component of reform of the US health care system (Gottlieb; Nutting et al., 2009). Many benefits have been reported to emerge from collaboration, including improved information processing and patient outcomes and reduced health care costs (Dietrich et al., 2004; Institute of Medicine; Jackson et al., 2003; Speir, Rich, Crosby, Fonner, & Cardiac, 2009). Gray (1989), defined collaboration as "a process through which parties who see different aspects of a problem [or issue] can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 5).

Despite the national calls to collaborate, many people remain reluctant to engage in collaborative relationships (Topping, Hueston, & MacGilvray, 2003). This is in part because collaboration is complex and does not have an accepted standard definition (Blount, 2003). A common or colloquial definition of collaboration emerges from its Latin roots *Col* (together) and *Laborare* (work), yet this differs little from common definitions of cooperation or coordination (Blount). Chrislip (2002), a leading researcher in the field of collaborative leadership, defined collaboration as “mutually beneficial relationships between *two or more parties who work together toward common goals by sharing responsibility, authority, and accountability for achieving results*” (italics added).

Table 1. *Spectrum of Social Action*

Table 1 <i>Spectrum of Social Action</i>	
Coadunation	Unified structure and combined organizational cultures
Collaboration	Shared authority, responsibility, and accountability with integrated strategies and collective purpose
Coalition	Limited alliance
Coordination	Alignment of processes
Cooperation	Shared information and mutual support
Communication	Shared information
Coexistence	Independence
Competition	Rivalry for supremacy
Counteraction	To oppose by contrary action

Table 1 describes a spectrum of social action with a gradient reflecting the degree of alignment or integration of resources, goals, and decision making. It highlights where collaboration fits in a spectrum of human activity in which goals and resources may be aligned, subsumed, or set in opposition. This is expanded from Cook-Lauder (2005), Frey, Lohmeier, Lee, Tollefson, and Johanning (2004), and Gajda (2004).

Hesitation to collaborate is understandable given this definition as shared authority and accountability complicate decision-making, require dedicated effort and resources to maintain, and can result in uncertainty and loss of control (Blount, 2003; Dietrich et al., 2004; Nutting et al., 2009). For Cooke-Lauder (2005), “collaboration is not a process but a noisy, complex, unwieldy and unpredictable situation where the competing interests of different parties are always present, and where the resulting tensions and ambiguities need constant attention” (Cooke-Lauder, p.37). The complexity of defining and studying collaboration has even led some to doubt the rationale and benefits of collaboration (Zwarenstein & Reeves, 2000). Blount defined degrees of collaborative care that include coordinated care, co-location of services, and integrated

care. A variety of authors have sought to distinguish true collaboration such as that defined by Chrislip (2002) from strategies with greater and lesser degrees of integration. Table 1, adapted and expanded from (Cooke-Lauder; Frey, et al., 2004; Gajda, 2004), describes a spectrum of social action with a gradient reflecting the degree of alignment or integration of resources, goals, and decision making. It highlights where collaboration fits in a spectrum of human activity in which goals and resources may coexist without communication or coordination, may be aligned (coordinated), shared (collaboration), subsumed (coadunation), or set in competition, or in opposition (counteraction).

Academic Medical Centers (AMC) are organized along specialty lines into departments and divisions, with separate lines of authority and separate traditions of professional socialization. The specialty orientation of faculty meetings, quality assurance, finance, and other structural factors reinforce these divisions. Within each subunit (department, division, unit) there are individuals at a variety of skill acquisition levels, ranging from novice through proficient to expert. The AMC also has myriad spheres of activities often occurring simultaneously, including patient care, education, research, and community service.

The number of family practitioners who perform prenatal care or deliver babies as part of their regular practice has been declining (Cohen & Coco, 2009; Ringdahl et al., 2006). This has adversely affected obstetric outcomes and reduced the scope of practice expected of family physicians (Nesbitt, 2002). Most family physicians that practice obstetrics need to work closely with obstetricians when patients require operative delivery. A few family physicians, particularly in rural areas, do include operative obstetrics including cesarean delivery in their practice. The relationship between Family Medicine (FM) and Obstetrics and Gynecology (OB/GYN) has been openly hostile in many settings (Good, 1998). Concerns about liability for shared care, cultural difference, and competition for patients have resulted in battles over privileges and turf, and reluctance to collaborate (Good, 1998; Nesbitt, 2002; Topping et al., 2003). The experience of obstetrics during residency training, in collaboration with Obstetrics (OB) faculty and residents, is an important factor in family physicians' decision to practice OB (Ratcliffe, Newman, & Stone, 2002).

The professional differences between Family Physicians and Obstetricians, and the evolution of both specialties explain some of the tension between FM and OB. The modern obstetric unit is a stressful environment. Modern technology and the expectation of excellent outcomes come up against an inherently risky and unpredictable nature of the delivery process. There are also enormous potential penalties for negative outcomes in terms of legal and financial liability. In this context, the perceived risks are high and the tolerance for error or adverse outcomes are low. Obstetrics and Gynecology comes out of a surgical tradition with a hierarchical learning structure that stresses hard work, content expertise, technical and procedural skills, and the ability to efficiently manage multiple risky scenarios simultaneously. Family Medicine emerged as a specialty in its own right from the field of General Practice in the late 1960s. It emphasizes a generalist approach of wide breadth, focusing more on communication, relationships, and maintenance of continuity; and providing care from cradle to grave. The scope of FM practice has been shrinking due to the increasing specialization of the modern health workforce in the US and OB is one of the services most frequently dropped. The two

specialties also tend to diverge on the perception of risk. Family Medicine prioritizes the normalcy of the birthing process and OB prioritizes risk reduction.

Method

The question addressed through this study is: “What are the essential invariant elements of collaboration between the departments of obstetrics and gynecology (OB/GYN) and family medicine (FM) at an academic medical center?” By “essential, invariant elements” we mean the abstracted essence of the experience, a “structural description of...the underlying and precipitating factors that account for what is experienced” (Moustakas, 1994, p. 98).

Investigator Bias/Background

The principal investigator David Brown (DB) is a family physician who was hired in 2001 to be Director of Obstetrics for a family medicine residency program in a large urban hospital and who is currently Chief of Family Medicine at a new college of medicine with a focus on interdisciplinary training and research. He had no prior training in qualitative research methods before launching this study. His prior clinical and educational experience made clear to him that collaboration with obstetricians would be crucial for his success, and that these relationships could be difficult. He obtained a “Faculty Enhancement Award” from the Society of Teachers of Family Medicine to make a two-week visit to an institution which described itself to be a model of collaboration (Berman, Johnson, Apgar, & Schwenk, 2000) between family medicine and obstetrics and gynecology. In order to make the most of the visit, and to begin a research career, he obtained a research stimulation grant from the American Academy of Family Physicians to conduct a qualitative study. He then set out to learn what qualitative research was by reading two texts on grounded theory (Locke, 2001; Strauss & Corbin, 1990). He requested a research mentor from the Chair of Family Medicine at the study site, who suggested J. Creswell to assist with the methodology, and later identified another of the authors of this paper who was interested in collaborating Lou A. Lukas (LL).

Lou A. Lukas is a family physician who was interested in women's health and who had previously trained with experts in qualitative and mixed method research in primary care (Crabtree & Miller, 1999). Her undergraduate and graduate medical training took place in two institutions where the relationship between family medicine and Ob/Gyn was tense at best. She actively negotiated this relationship during residency by forming an alliance with Ob/Gyn residents, and along with other peers, gradually established credibility for family medicine residents on labor and delivery after completing 100 deliveries during training. At the time of data collection she had been present at the study site for six months as a fellow in the Robert Wood Johnson Clinical Scholars Program and a lecturer in the department of family medicine, where she maintained privileges for low risk obstetric care.

David Brown read a text by Creswell (1998) that led him through a series of exercises and ultimately to select the method of phenomenology (Creswell; Moustakas, 1994). The two family physicians then developed a research protocol and Dr. Creswell

consulted on the protocol. The other authors are a sociologist who teaches qualitative methods who consulted on the coding scheme Marina Karides (MK) and a health educator and community health scholar (CB) who assisted with the analysis and writing.

Marina Karides is a sociologist with substantive interest in global studies, social inequalities, and social movements. She is a qualitative researcher and global ethnographer and has conducted field research outside the US including Trinidad and Tobago, the Republic of Cyprus, and Greece. She has two children and used midwives for both births, the second was a home birth.

Cheryl D. Brewster has a degree in health behavior and health education. Her work focuses on community based participatory research for which she completed a post-doctoral fellowship. She is a qualitative researcher, teaches qualitative research methods, and conducted research in the areas of HIV/AIDS, diabetes, physical activity and pregnant women, and healthcare access.

Phenomenology

Phenomenology is a qualitative research methodology for the study of subjective experience. It reflects an ongoing exploration, pursued by philosophers and social scientists since the 1800s (Good, 1994; Heidegger, 1996; Husserl, 1979; Schutz, 1967), of the nature of the social world. Philosophers and scientists have long searched for universal rules or meanings. At least since Aristotle, and particularly in the modern age, philosophers and scientists have looked to the external world of objects for answers. In modern times, since Descartes, the search has also turned inward toward the subjective internal perception of the experience of existence. Descartes identified his own perception as proof of his existence. Later writers sought to gain additional knowledge of the external world through intuitive and deductive analysis of their own internal experiences. Husserl asserted that our consciousness of the external world of objects is as much a product of our intentional act of attending to it as it is dependent on any actual object in the material world. Perception, asserts Husserl, is intentional or volitional. It is an active process. Thus our own perception is a creative act and we ourselves have a role in making the world we find. Heidegger found himself thrown into a world of objects with his own unique set of perceptions and potentialities conscious of other subjective actors who appear to have their own set of perceptions and potentialities. Heidegger found his perception of these objects and others to be shaded by “moods” such as “care” and “dread.” Blumer (1998), wrote that the way people view objects depends on the meaning these things have for them; this meaning comes about as a result of a process of social interaction; and the meanings of objects can change over time. Schutz reflected on the inherent difficulty in ever knowing the intended meaning of an action since its meaning is dependent on the historic context and time-frame of reference in which the action is interpreted. Good (1994) and others have described examples in which shared meanings are constructed within hegemonic social structures.

In the phenomenologic method (Creswell, 1998; Moustakas, 1994) the meanings ascribed by the actors themselves to their own actions are interpreted in the context of imaginative and intuitive comparison between their different statements and those of other actors in the social context, and of the existing literature on the phenomenon.

Recruitment of Participants

This study was centered on the Labor and Delivery (L&D) unit of an Academic Medical Center, and extended to various ambulatory clinical and administrative sites. The site was chosen because faculty there had published a paper describing their relationship as a model of collaboration between obstetrics and family medicine. Approval was obtained from the University IRB at the study site, and the departmental leaders, and all participants provided written informed consent. They were made aware that anonymity might be breached given the narrative nature of the data and that the site is known within the medical community.

We used a snowball sampling strategy. Departmental leaders and senior faculty in key positions were interviewed first, then residents of both departments from intern through senior level and nurses on L&D. Our sample size was 33, consisting of six FM faculty, seven OB faculty, six FM residents, seven OB Residents and seven nurses during a two-week field study period in May 2002.

The PI was introduced to faculty and residents by the Chairs of the two departments at their respective departmental meetings. After a presentation about the study, faculty and residents volunteered for participation. The Chairs were two of the first interviews. Other participants were identified because they were present on L&D during the study. Each participant was asked to identify additional potential participants, particularly those who might have a different viewpoint.

Data Analysis

The phenomenological method, as described by Creswell (1998) and Moustakas (1994), and based on the work of Husserl (1979), is a qualitative method to create an exhaustive description of how a phenomenon is experienced, and the structures that lead to that experience. The analytic design, adapted from these two sources involved the following stages:

Epoche. In a form of “structured brainstorming,” DB and LL explored their beliefs, experiences, biases, and the medical literature on the subject of collaboration between family medicine and obstetrics and gynecology and then sought to “bracket” them, setting aside presuppositions to look at the problem freshly, “as if for the first time” (Moustakas, 1994, p. 85). The bracketing was principally implemented through an inductive methodology which began with open-ended general questions about collaboration that elicited the participants’ narrative descriptions of their experiences of collaboration, setting aside (for the start) “objective theoretical interests” (Husserl, 1979, p. 135).

The interview guide (Table 2) was designed to seek the experiences of the participants inductively, with open-ended questions aimed at eliciting answers where the participant would elaborate on their answers, providing background, perspective, and rationale. Follow-up questions were guided by the informant’s response to the initial question and including “descriptive,” “structural,” and “contrast” questions (Crabtree & Miller, 1999). Interviewers noted topics mentioned in the course of the interviews, and

asked participants to suggest individuals with a viewpoint different from their own. They were also asked to provide any documents that shed light on the collaboration. We used the documents provided, such as policies and procedures, manuals, and case review documents to confirm the local policy and procedures as described by participants. Open-ended questions framed by expectations or literature such as those related to more specific questions about the impact of the locally developed collaborative protocols and the impact that nurses played in the relationship between OB and FM were added to the end of the interview guide.

Table 2. *Faculty & Resident Interview Guide for Phenomenon of Collaboration*

Intro: Hi, just to clarify, we want to know about your collaborative relationship on OB including the OB doctors and Labor and Delivery (L&D) nurses. By collaboration we mean all aspects of working with people. Some people have different levels of collaboration, for example, the leaders of the departments may have developed policy whereas other people interact mostly on labor and delivery or in other clinical or social settings. We want to hear about all levels of working with, or collaborating regarding OB, both at the individual and institutional levels.

First I'd like to know a little more about you personally:

- What is your level of training? (OR) How many years have you been doing this?
- Where did you go to medical school (and residency?)
- About how many deliveries have you attended?
- What is your comfort level with OB?
- What is your current involvement in obstetrical care? And what are your plans for the future?

Residents and Faculty:

- Can you describe one specific interaction with someone from the other department that was really good?
- What made it particularly good?
- How did this experience affect you?
- How do you think this affected your patient?
- Can you describe one specific interaction with someone from the other department that was bad or difficult?
- What made it particularly bad?
- How did this experience affect you?
- How do you think this affected your patient?
- How would you describe your overall experience working with (OB/FP)?
- How does your experience collaborating with (OB/FP) compare with other collaborative relationships with other departments like medicine or surgery? Can you provide an example?

- (For FP) How have your collaborations with the OB department effected your decisions to practice OB in the future? What other factors are important in that decision?
- (For OB) How have your experiences with family practice made you feel about working with family practitioners in the future? What do you think of Family Practitioners doing OB?

Residents only:

- Tell me about your experiences working with L&D nurses.
- How have L&D nurses affected your training? (What have you learned from them?)
- How do L&D nurses influence the care you give to patients? (Tell me about a significant experience you've had? How did it affect you?)

Faculty only:

- Describe your experience of collaboration between the two departments.
- Do you have experiences outside this institution? How would you compare those to your experiences here?
- Did you have any role in developing the collaborative process here? What was it like before formal processes were in place? How have they changed?

Finishing up:

- Are there any documents or written materials that are relevant that we should look at?
- Which of these are most useful to you?
- Do you know anyone who has differing experiences that we should talk to?
- Is there anything else you've thought of you'd like to add?
- We may be contacting you later to confirm some of the analysis we do, is that alright with you? Thank you.

Horizontalization. (Creswell, 1998; Moustakas, 1994): All statements meaningful to the research question were identified and given equal weight. All interviews were recorded and transcribed for analysis, assisted by QRS N*Vivo qualitative research software (QRS International Pty Ltd., 2001). Each transcript was read through and duplicate and/or extraneous material was removed to create a set of individual narratives in the words of the participants. An initial set of general themes (codes) was created based on concepts identified in the initial reading and horizontalization and additional codes were added as emergent concepts appeared during coding. The software was used to apply one or more codes to each block of text that could be conceived of carrying a distinct interpretable meaning. At times, multiple codes were applied to different overlapping parts of a block of text if more than one code applied.

Phenomenological reduction. Statements were grouped into “meaning units” and a “textural description” of qualities or “essential constituents” of the experience was synthesized (Creswell, 1998; Moustakas, 1994). The software was used to create coding reports, lists of statements grouped by each code, and then the PI once again read through all of the grouped statements, making notes about them in the margins, including intuitive analysis, “a consistently reflective attitude toward the “how” of the subjective manner of givenness of the life-world and life-world objects” (Husserl, 1979, p. 143). An example of the process is presented in the Appendix.

Imaginative variation. All possible interpretations of the experience are assessed; including the researchers’ own experiences (Creswell, 1998; Moustakas, 1994):

The task of Imaginative Variation is to seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions. The aim is to arrive at a structural description of an experience, the underlying and precipitating factors that account for what is experienced. (Moustakas, pp. 98-99)

As co-authors, we worked together to construct a narrative that described the key themes and structures that emerged as important to this collaborative context.

Synthesis of “meanings & essences.” (Creswell, 1998; Moustakas, 1994) Next we conducted an intuitive integration of the structure and texture of the experience, elucidating meanings and essences resulting in an exhaustive description of the phenomenon under investigation that is rooted in the data and is reflective of the essence of the participant’s experiences, which is presented as the results section of the paper.

Triangulation strategies. Specific events were discussed with multiple participants (member checking) comparing a variety of differing viewpoints. Findings were also triangulated through direct observation of the environment, documents, and clinical and academic routines. The Chairs were asked to review this manuscript at several points in its development and share it with other faculty. They provided feedback through several iterations, always supporting the findings.

Results

In the following section we present themes and subthemes that emerged from the data. We begin by presenting themes that capture the collaboration experiences as described and move forward to how it is qualified by participants. The early themes present the context for later themes and subthemes.

Working with Others

Working alone is less complex than working with someone else, “Some of the chiefs just feel like it’s easier if they take care of the patient.” (FM Resident) Solitary work can allow me to concentrate deeply on a task, without distraction. When I work alone, I can change objectives or methods as I like. I can rapidly respond to new information and adjust my approach.

When I work with another, I gain their skills and expand what is possible to achieve, “I’m glad because we’re really all really busy. (Laughs) I mean, it’s nice to share that corporately.” (OB Attending)

Working with another, I must also deal with that person’s agendas, moods, & personality. Suddenly the processes of communication and coordination become important, adding complexity. The more people who are added to the process, the more complex it becomes.

When I work alone, I set my agenda, my schedule, and my strategy. My own needs are my concern. If I work with someone else, the other person’s needs are also an object of concern and there is a risk of conflict. I either need to learn to follow their agenda, get them to follow my agenda, or try to negotiate a shared agenda. If there are two of us, we want to know, “who’s in charge?” (OB Attending)

If there is a clearly defined hierarchy, then we know who has authority, responsibility, and accountability. If the hierarchy and objectives must be negotiated, that adds uncertainty and complexity to the decision making process. These negotiations may lend themselves to conflict, particularly if there is a difference of opinion regarding the objectives or hierarchy.

The Conflict within Collaboration

Not all elements of collaboration go smoothly. Tensions arise out of the complex interactions of boundaries, turf, power relationships, competence, the liabilities that arise from the consulting relationship, gaps in supervision or communication, personalities, and variations in style and professional socialization.

You don’t even want to be in the room when Plastic Surgery and ENT go at it over who gets to do facelifts (Laughs). I mean, blood flows in the halls. This institution is very turf jealous and if anything, the difficulties between OB and Family Medicine are about the least of them around here. (FM Attending)

An FM attending explains the de facto power of OB on L&D, and cites the role of nurses in enforcing that:

We don’t determine the culture up there. We are... large minor players. ... Some of the folks [nursing staff] up there... basically... walk the halls with a large club with “The Way We Do It Here” emblazoned on it and if

you don't do it the way we do it here, POW! ...Others are much more flexible and tolerant... It depends a lot on the individual.

Because FM doctors spend less time on the unit than their OB counterparts and have comparatively less OB knowledge and skills, the nursing staff often has less trust in them.

When I work with the OB residents...this is a big difference, it's a major difference, I'm stuck with them for four years, I want to get along with them... with family practice if I try and it doesn't work I don't lose as much because they're only gonna be around once in a while but the OB I got for four years. (Nurse)

When the nursing staff question care, they sometimes bring it to senior OB residents or faculty rather than the responsible junior resident or FM faculty. This indirect communication can raise tensions and result in conflict.

It's like turf. It's like when the nurses complain to the obstetrical attendings that she doesn't feel comfortable with the way this patient is being managed and that has happened on various occasions. (OB Attending)

Power difference greatly impacts how working with others is experienced, as described by an FM attending:

You're dealing with them where you are at your limit, and they're pretty much dealing with their level of expertise, and so you're trying to prove that you're competent, but you're not at the level that they are.

It is quite a challenge to be new, junior, and untested:

It's very difficult to come into a department for a month with 30 new faculty all of which have a different and the right way... to do a delivery ... and then to be potentially kind of talked to roughly when you don't get it right. (FM Intern)

Another FM attending described how it can be intimidating to ask for help,

I guess it would be with all consults in that, in that the university setting it's never quite as friendly as you would initially hope. And you do dread calling consults. You hate calling people. Once you get to know people and they get to know you, it's a whole different story, but it's always difficult to call people and say I have this patient I would like you to see um because it's never this receptive thing... You know there's still the kind of rolling their eyes

Obstetrics faculty and residents commonly reported conflict to emerge from competence, communication, and supervision gaps. An OB attending reflected on this:

I think we just have to be intellectually honest with ourselves about what our scope of expertise is and is not. And that's gonna vary from person to person and it doesn't matter whether it's in obstetrics or family medicine or surgery that's I think a basic question we all have to ask ourselves...I think just from my prospective [FM doctor] doesn't recognize some of the clinical scenarios that they get themselves into.

Many obstetricians described the primary concern with collaboration being the added risk of being responsible for someone else's decisions, as described by one MFM attending:

Obstetricians are notoriously reticent or resentful... when called in to bail someone out at the last minute... And the medical/legal issues of being more liable if you don't know exactly what's going on, and you are called in the middle things going haywire.

In contrast, FM faculty and residents spoke more about the respect shown them, and challenges to their ability to learn or practice, as explained by a FM attending physician:

We asked our consultants for a consultation and they just took off [took over the case]... Apparently thought so little of us that they did not respect us at the patient's physicians... there are certain areas where we officially have privileges that we cannot really exercise because either we do it seldom enough or often it's because it's some procedural thing that OB really regards as their turf that they haven't seen us do or aren't comfortable with us doing and the issue of interdisciplinary respect comes in... That is part of our credential. I have privileges do to that. We choose to exercise them and they're not familiar with that and they believe that it is their role and their right to police our privileges.

Personality conflict was repeatedly cited by OB/GYN, FM, and nurses as the most common cause of conflict.

This individual doesn't engender a lot of rapport with the OB nursing staff and that's been a repetitive issue. So the whistle gets blown and then we get involved, and then it escalates from there. (OB Attending)

When these cases were explored individually, it appeared that individuals on each side of a conflict were protecting some aspect of their values or turf and that when contrasting vision, values, or turf issues were brought together, particularly combined with personality issues, conflict erupted. Even when other issues were involved, personal

characteristics often mediated whether situations turned into conflicts. The best interest of the patient was often cited as motivation by individuals on both sides of a conflict.

Variation in style and professional socialization was another complicating factor, as described by an FM intern:

We're fundamentally trained differently than a lot of the OB's, and we're... trained to be less invasive on our patients, and... a lot of those skills don't transfer over to the OB service. ... I kind of get in FP mode and I get in OB mode... and its hard when you're doing deliveries side by side, because you know that your FP labors... they don't want to do interventional kinds of stuff and the OB people just want to pit and rupture, and.. and get 'em going and get 'em done.

Although many of the doctors acknowledge the conflicts associated with collaboration, the departmental leaders and others were just as quick to offer solutions to these conflicts.

Conflict Management

The OB/GYN Chair saw conflict as an issue of personalities and role definition, to be managed,

Almost all of them have been personality-based. Individuals who either didn't understand their roles or didn't understand their own limitations on both sides... Dr. [FM Chair] and I dealt with those.

A senior FM faculty pointed to communication as the root of conflict, "the worst [experiences] are the ones where one side doesn't know what the other side is doing." The FM Chair took a view of conflict as inevitable:

If [the interaction is] not positive or not ... as good as I would like... I don't really see that as an issue of some larger philosophical issue ... some problem between the two departments, or some issue related to our role in OB. I just see it as... random... chaos theory in the universe.

For him, the way to manage this was through the combination of service independence with quality assurance, and day-to-day flexibility; keeping a focus on quality of care:

I'm not very possessive about... turf issues at the time of a particular consultation... I'm much more interested in doing what needs to be done to take care of the patient and to do it well and to not have fights or disagreements or... lack of... certainty kind of spread over into the quality of the patient care... However we sort out the responsibilities... who has privileges to do a certain thing, or... who should take the lead and whose service is the patient on, and all those kinds of administrative issues, I think are relatively secondary to the larger issue which is... everyone is

there for the benefit of high quality patient care, and that we should function with that as the, sort of the guiding principle.

Both departments were observed to have active quality improvement processes in which cases were discussed at regular departmental meetings. They kept and reported outcome data. Conflicting cases were reviewed in quality improvement committees, and there was consensus that there was good quality care. Problem cases raised in interviews addressed issues of turf, boundaries, or practice style in the majority of cases rather than of clear cut incompetence or negligence. Issues of competence were managed through overlapping cross-checks built into the system.

One FM faculty member, who aggressively maintained control of patients whenever possible, and without much conflict, described the importance of respectful communication:

I communicated with the obstetrician early on...rather than surprise 'em with it... I opened the door for communication right away... So they will bring up what they think needed to be done, and if you have an answer say, "I've already done that, I've thought of that." But if you haven't, say, "Oh, good idea, thank you for mentioning that one."

This model was appreciated by a senior OB resident:

I think the most important thing is good communication. If we feel that... we've got a resident who's taking care of patients but also knows when to ask for help...I like to know what's going on there. Sometimes they'll just page me or they'll just walk over or give me a heads up. Sometimes if I don't hear from them I'll call over or just walk over and find out what's going on.

Mutual respect and responsiveness are cited as key factors by faculty, residents, and nurses. The trust generated by good communication, tactful negotiation, and positive outcomes is protective against conflict in subsequent interactions. In contrast, a number of specific individuals also described a cycle including conflict, unproductive or delayed communication, disrespect, and mistrust. Overall, many of the clinicians reported relying on departmental leaders to play an important role in creating a collaborative environment.

A Shared Vision of Collaboration

Multiple informants in each department cited the importance of the Chairs' leadership in establishing and maintaining a collaborative interdepartmental environment. An OB/GYN attending said:

Well, our Chairman and their Chairman work closely together. And I know our Chairman has done a lot to include Family Practice.... And you know, it just doesn't seem like there are any issues... no one's fighting

over patients, no one's fighting over, you know, the income that it generates, that I can tell.

Both Chairs took actions to achieve a more collaborative environment including: changes in faculty, developing common consultation guidelines and joint policies, developing autonomous services with rigorous quality improvement and supervision procedures, careful attention to billing and outcome tracking, aligning structures and incentives to support collaboration, intertwining the resident training programs, encouraging cross-disciplinary research, and establishing and maintaining multiple communication pathways.

The FM Chair explained the importance he gave to the relationship with OB/GYN

We had to make this relationship work... We had nowhere else that we could practice Obstetrics. We had a few years of history in a very low level of obstetrical practice here, and... we knew we had to make it work... one of my top three or four... essential activities which we had to be successful. We were making good progress, but not great progress, until... Dr _____ came as [OB/GYN] Chair...

The OB/GYN Chair explained how collaboration and respect for FM took precedence in how he led his department:

One of the reasons I came to Michigan was an opportunity to... re-establish work with family physicians as part of an increase in primary care operation... There were some faculty members in OB/GYN, none of whom work here anymore, who really thought the family physicians shouldn't do pap smears and shouldn't do colposcopy and were just kind of living in a different world in terms of what the reality was. They were not accepting, you know, "why should these family docs be doing deliveries?" I mean, it was just kind of denial that they were in. So we took the people who were in denial and just marginalized them.

On the FM side, significant investment of resources and personal involvement formed the core of the Chair's vision:

When you're trying to develop some autonomy and professional esteem... you can't have that if you're not physically present, if you're not willing to deal with problems when they show up at three in the morning... [I]f... the family physician's idea is, well I'll back up my residents during the day, but we'll just ask the obstetricians to do that at night, then that's not gonna go very far... So you have to recruit a group of people who are very high quality who could hold their own, practice good obstetrics, know what they're doing, have good judgment.

The Family Medicine and Obstetrics services were organized as autonomous services, with shared clinical protocols. The FM Chair described his vision of autonomy:

The key... representation of this is that if a patient... has some complication, or a family member... sends a letter of complaint or something, and it has to do with one of our patients, the system inevitably turns to [the OB Chair] and says... could you review this or what is your opinion about this and [the OB Chair] looks it up and says, well that's not my patient, that's Family Medicine's patient. Talk to [the FM Chair}... People ask us about our projections for our volume instead of just talking to OB... We could provide the quality assurance...risk management... M&M (Morbidity and Mortality Review)... But I would also say that the OB leadership... isn't gonna do that until they trust us... there's nothing in it for them to be magnanimous if they think that it's going to compromise patient care.

The OB Chair shared this vision:

I think we both have a similar vision in terms of what we want to do ...I think first of all that it was important to just show respect for Family Medicine's capacities to do their own quality assurance. Secondly, from my point-of-view, it's probably much more effective to have family medicine do their own quality assurance and discuss their own cases there. (OB Chair)

The two departments developed formal consultation guidelines through negotiation that were periodically reviewed and updated. The guidelines provided specific direction about when consultations should be requested, when cases should be co-managed, and when care should be transferred. The consultation guidelines and a variety of policies and procedures are tacked up in plain view in the FM call rooms, and are included in the "Obstetrical Survival Manual," a spiral bound pocket-sized book of local protocols and guidelines for care of common problems encountered on L&D; also available internally on the Internet. Residents and faculty reported that these have greater importance for the FM providers because they provide specific enablers and limits to their scope of practice, and because FM providers, particularly residents, are typically at a phase of skill acquisition that is more rule dependent (novice or proficient) than OB residents and faculty who spend much more time in obstetric care allowing them to achieve greater content and procedural expertise. This could also be seen in the way that the FM department faculty and residents kept close tabs on the specifics of the guidelines. As noted by an OB resident:

I think that's helpful for the FP's. I'm not sure if we still give that out to the FP residents cause the ones I've seen who've had a copy have found it useful but I'm not sure we formally give them out to the FP residents. I think it's called like the labor and delivery survival guide.

An FM intern (first year of postgraduate training) on L&D relied heavily on the survival guide:

Someone took a lot of time and wrote a whole guide which is in my back pocket, obviously... and I carry with me... on page one it says what ... Family Practice handles independently, what things we should get, consult on, and... what situations merit transfer of care. So that's very helpful to have.

While on paper they appear very specific, in practice they mandate negotiated role definition but often do not specify the outcome of that negotiation. Rather than serving as a protocol to mandate specific actions, they mandate conversations about care, and situate those conversations in the context of previous agreements. Both FM and OB/GYN residents and faculty described the guidelines as flexibly implemented. An obstetrician explained:

I don't see the need to go quoting the guidelines song and verse... it's gonna vary from person to person. There are some people who are comfortable with one scenario and some people aren't comfortable with that scenario... some people want to co-manage, some people may want to transfer outright... I'm usually pretty flexible about that.

While the creation and maintenance of the consultation guidelines provide one sort of communication, many others also existed. An FM attending explained:

We have a perinatal joint practice committee that I'm on... we meet monthly to talk about issues up on labor and delivery, with OB, and family medicine, and the nurse midwives, and so we're always discussing... protocols.... We communicate these issues very well... between the two departments.

Family Medicine and Obstetrics Quality Assurance directors communicated with each other. Family Medicine faculty felt represented and "in-the-loop." Obstetrics faculty were comfortable that FM faculty and residents were following the same policies.

Beyond policy, the leaders of the two departments recognized that collaboration played out individually and interpersonally at multiple levels, and they created structures to enable their faculty and learners to get to know each other.

"Growing Up in the Same Sandbox"

Mutual learning and relationship development were core to the collaborative vision described by the OB/GYN Chair,

One of the things that I felt pretty strongly about and now let me and let me make it even more explicit is that I think people growing up in the sandbox together is very, very important. I have a feeling that a lot of how I am is a reflection that ...I grew up in a sandbox with a lot of different people... a lot of my willingness to collaborate with nontraditional collaborators has been role models, it's been not just family medicine collaboration but other kinds of collaboration. A lot of my

formation was done with a non-physician teacher. I think that may have been important. If people grow up in the same sandbox...they end up with not only some shared values but also some shared respect just as that moves up through the system.

Faculty and residents from each department got to know each other, opening opportunities for friendships, mentoring, and partnership on a variety of personal and professional levels. An OB/GYN resident reported,

Well I have a number of residents that I've rotated with... and subsequently have become friends with outside of the program. And so probably the most positive experiences would be non-work related more of a social basis.

The training programs of the two departments were interwoven. Family Medicine interns had a specifically designed sequence of rotations that provided them the tools to succeed: neonatal resuscitation first, then low-risk OB under the direct one-to-one supervision of a FM attending, and finally integration of the FM intern as a functioning integral component of the OB service. This design involved significant departmental effort to coordinate. Obstetrics and Gynecology residents learned primary care in a one-on-one environment with experienced FM faculty. Initially as peers and subsequently as supervisors of junior FM residents and as a consultant, OB/GYN residents continued relationships made early in training during their ongoing interactions on L&D.

The family medicine service was co-located on the same low risk side of the labor and delivery unit as the midwifery service and the low risk patients on the obstetrics service. Its hierarchy was independent of the obstetrics department. There was a family medicine attending responsible for the service, with residents and interns working under him or her. There was a complex call system to enable continuous presence of attending physicians and residents on the service. The patients from this service came from the FM department clinics. The primary care provider (attending or resident) worked with the FM service to manage the patient together. Shared care on the FM service was between residents and faculty of the same specialty. It was through consultation that the care became interdisciplinary. Family Medicine residents also rotated on the OB service so they got to understand the routines of that service, which were different from those of the FM service.

An FM attending noted,

It's much easier after you've worked with people and know them to go to them and say, "I have this patient will you come and take a look." They know you, they know your skills, and you also know each other on a first name basis that it's much easier.

The collaborative model promoted legitimate participation (Lave & Wegner, 1991) of all team members including nascent interns and progressing to senior attending physicians with rather advanced skills. Full participation reinforced trust and learning. Family Medicine residents and faculty demonstrated their capacity for alleviating the

often-daunting amount of work on L&D, gaining competence and confidence. This differs from less collaborative relationships in which the visiting resident on a service is shadowing the residents of the host service—neither helping with the work nor demonstrating competence.

Discussion

Collaboration is a subjective intentional act set in the context of a world of subjective actors each with their own set of perceptions and potentialities. It involves the creation of shared meanings in the context of hegemonic social structures. To share decision-making authority and accountability adds complexity and necessitates communication and negotiation. Each experience with collaboration creates new subjective meanings which promote trust or mis-trust and lead to subsequent experiences being framed by moods such as “care” or “dread.” The meaning one ascribes to collaboration, whether framed by care or dread, greatly impacts one’s approach to it. When dread impedes, delays, or shapes communication, it can create a cycle of negative experiences with collaboration, decrease the intent to collaborate, or lead to a preference for more independent action. Similarly, care promotes timely respectful communication which strengthens collaboration. A history of successful collaboration in a community, an organization, or an individual, and supportive environment, can promote comfort with and future intent to collaborate. Whether viewed with care or dread, collaboration has myriad meanings to those involved in it, framed by past experiences, adding psychology to the collaborative process. Given the complexity added by collaboration, intentionality must play a large role in the decision to do the work required to sustain a successful collaborative process.

Interdepartmental collaboration in this setting was clearly intentional. The two departmental Chairmen shared a vision and made collaboration a priority. Their shared vision and purpose set the stage for action. They planned for collaboration and maintained it by structuring their departments to be co-located, autonomous, and mutually interdependent, with their trainees “growing up in the same sandbox.” They hired, trained, promoted, and reimbursed their faculty with the collaboration in mind. They shared curriculum, skills and relationships at multiple levels. They developed shared clinical policies, shared research projects, longitudinally integrated curriculum, autonomous clinical services with their own rigorous quality improvement processes, and formal and informal communication channels; and they maintained ongoing attention to the interdepartmental relationship in staffing, reimbursement, role definition, work flows, communications, and myriad departmental policies, procedures, and processes. We identified ongoing tension around specific cases, individual personalities, and challenges to traditional boundaries. The collaborative dynamic between department Chairs and the multiple structures that they maintained established a collaborative environment and assured that individual conflicts did not harm the overall inter-departmental relationship. The significant effort and involvement by the department Chairs and extensive resources devoted to structuring this collaborative relationship underscores that collaboration is not a simple process and is greatly impacted by organizational leadership if it is going to be an organizational process. (Austin, 2000)

Collaboration is a conflict resolution strategy (Gray, 1989; Schulman, 2006) and an alternative management model involving a less hierarchical and more participatory organizational strategy (Tricket & Ryerson Espino, 2004). Nonetheless, collaboration does not eliminate conflict. In fact, shared decision making makes conflict inevitable. The centrality of relationship development, negotiation and conflict resolution to the phenomenon of collaboration reinforces the need for any effective collaboration to include attention to these processes.

Some individuals, situations, or organizations may not be best suited to collaborative work. Some individuals prefer not to share decision making; preferring a more independent or hierarchical decision making process. Consultation, coordination, transfer of care, and supervision, for example, do not always necessitate shared decision-making. Individuals do not always recognize when they are in fact engaged in collaborative relationships, with implications for communication and decision-making that can lead to breakdown in communication, and conflict. It is important to distinguish between members, objectives and situations that require or benefit from collaboration and those which may be better suited to coexistence, communication, coordination, cooperation or even competition or counteraction; each of which may have value in the right situation, and may require fewer resources and processes to support (Table 1). Collaboration may be most appropriate in the context of complex problems, skilled leaders, shared vision, unique purpose, interdependent stakeholders, mutual interests, trust, appropriate members, flexibility, and supportive environments with sufficient resources, structures and processes to support collaboration including attention to relationship development, communication channels, and the staging and pacing of collaborative work. (Mattessiche, Murray-Close, & Monsey).

Limitations

This study was conducted at a single site, though many participants and the researchers were able to draw on experience from other institutions. It also relied on observations and recollections of people still present in the environment; those who have left may have a different impression of the relationships. The observation period was limited so circumstances may influence participants' memories of past events and does not predict the future, particularly in the case of changes in leadership. In addition, the researchers conducting interviews were family physicians and follow up questions may reflect the bias of the interviewers. The model of training for family medicine residents in this setting is primarily non-surgical. Faculty and residents of both departments expressed reservations about whether FM physicians in this setting were adequately trained for rural practice without good obstetric backup or additional training. Patients were not interviewed, so that perspective is not reflected. Future research may examine collaboration at other institutions and between other departments. Prospective studies are required to evaluate the impact of implementing collaborative programs based on the essential elements of collaboration revealed through this study.

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Appendix

A sample of grouped meaning units and associated interpretive notes related to the NVIVO node "Questions of Competence." Names are pseudonyms to preserve confidentiality.

Knowledge, skills, attitude

unprepared don't understand limits, roles problems with communication, personality lack of respect not keep up = guidelines uninterested in reliable skills/knowledge poor don't recognize situation of past experience working together but past experiences chip on the shoulder

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Project: OB-FP Collaboration User: Administrator

Node: Questions of Competence-Skills-Knowl
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Document 1 of 34 Bishop
Passage 1 of 1 Section 6, Para 6 to 8, 1281 chars.

Between the OB and FP physicians themselves, outwardly I would say there's a lot of, umm I've noticed in medicine in general lot of respect, and a lot of collegiality on the surface, but I have witnessed some so-called backstabbing, and the typical thing that can go on when someone's not aligned with another person's um, level of performance. Oftentimes, it doesn't happen that often with physicians that I've noticed, but at times, it's too bad that that occurs. If I had a complaint or a problem when someone didn't go to that person directly, instead they chose to lessen their anxiety, they talk on other people. I think there's an ultimate amount of respect there with the physicians.

For instance, if I'm specifically working with a doctor... well I can be specific... I was working with a foreign-trained Family Practice resident, and my impression was that he wasn't able to think really quickly on his feet when we needed him to in an emergency situation, and later our obstetrician, who's one of our OB's I had told me that he seems to have a problem with carrying things going on his head, and he doesn't seem real sure of himself. That's about all he said. "So, I haven't yet [seen] really had FP OB interaction." I can't really say that, not really badly.

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...[P]ersonally I think that the quality of care is extraordinarily high and that the patients benefit tremendously from this... system that we have.

If you took us out of the picture and all of the patients we care for went to... OB clinics or had their obstetrical care carved out, I'm sure that it would all work out but...

If you... take OB out of the picture, and say this is... Family Practice... only situation in which backup is... cumbersome or difficult or... there's some... barriers there, I'm sure that we could... figure out how to do that... but the combination is far superior,

and so I think the ability to have a free flow of information and free flow of... communication... a comfort by the family physician in raising issues of concern without feeling like the patient will be taken away, or the physician will be demeaned for the question, or for not knowing something...

...and vice-versa, the OB... service having comfort that when they receive a request or receive a referral that there's been some reasonable care that's taken place beforehand, that things have been done in a way that they consider relatively proper, that requests aren't just... dumped on them when we can't figure out what to do without... good care up to that point, that there's a good follow up.

That they know, for example, if they do... a... section on the patient... of ours, that the patient's coming back to me for follow-up or for post-partum exam, etc. the... obstetrician never really sees the patient... after that point. They have trust that... post-operative result was good, that the post-operative care was good, that everything matters.

So, I think that the... system is better, therefore the patient care is better, therefore patients are served better with this collaborative approach.

It's not just an issue of, well, we have to do this, he's kind of figure how to make it work. It's an issue that the overall system's actually better because of this...

I think that the relationship is critical. I don't think you can function without effective collaboration and communication...

*role modelling
Finance?
safety - systems
- GA
- supervision
education*

*Essential elements of collaboration
understanding of roles
some shared purpose
communication*

*mutual understanding
competence, diligence
respect - mutual
presence
mutual nurturing
interdependence
leadership
personal relationships*

if for some reason it were very... unproductive... malignant... difficult, then... that would make it very hard to continue to practice...

I think this is an area where family physicians absolutely, 100 percent, have to have effective communication, or it's not sustainable, your life is miserable, patient care is poor.

If you think that every time you ask an obstetrician a question that they... are going to... yell at you, use the patient as a... or... against you, or... the medical staff, or file protests the next day... which... has happened in the past... that would be an untenable position for continuing to practice.

So, I think that this is a... mission critical requirement for continuing to practice.

There are obviously a whole host of other issues in terms of... time... continued... comfort with skills... the desire to be a role model for residents and students and other professional students... sharing with other faculty members so that coverage is available and lots of other issues...

But the relationship with obstetrical consultants is... critical.

Document 3 of 34 Black
Passage 1 of 2 Section 6, Para 21 to 63, 653 chars.

I don't necessarily feel like they're questioning my judgment... mostly just frustrated [when OB's do their own assessment]. I think they have a different view of what's reasonable. I've maybe got somewhat past feeling like they're questioning my judgment. I think I need to feel that way more. [With] time and self-confidence, you just develop a feeling that you know what you're doing is right and you don't really care if they think that [it's not]. Sometimes I feel like we don't get much say in what happens in a situation. Let's say a situation where they might just say "Well, we're taking this patient" and that doesn't really set very well.

Passage 2 of 2 Section 6, Para 57, 419 chars.

Being a resident versus being attending, I remember being told that I was not doing things right at times. I don't think anybody is very likely to come... and yell at me anymore [Laughing]. There probably were times that I did things wrong but the situations were really more difference in style or just... you meant when you really feel like you were doing things right and somebody gives you a hard time about it.

Document 4 of 34 Cort
Passage 1 of 4 Section 6, Para 21 to 45, 6082 chars.

The only really negative interaction with the Family Practice Department as a whole has actually been with one particular faculty member, and that's been a repetitive issue over the years that I've been here since 1985. And that's not unique to me, but to other members of the faculty as well. So it's just an individual that has his own particular ideas of obstetrical care, and they sometimes cross into areas that we feel are not particularly good to share. In other words his perceptions are sometimes at odds with ours in terms of the care of the patient, or what should be done at that particular time.

A patient [for example] who had a retained placenta, and with a retained placenta there's always the possibility of elevation of surgical care that would get into an area that obstetricians are particularly skilled and trained in taking care of, not a family practitioner. So that patient literally a retained placenta should be at least co-managed if not managed completely by an obstetrician. At least attending an attending, and certainly the residents and the family practice can be somewhat participating so that they know what's going on and what the concerns are. In this particular instance we had some words outside the room, and it was sort of an argument that I think the patient should be transferred to our service. No, I think we can take care of that, and if we run into difficulties then we'll call you. That kind of attitude has prevailed over the years with the interaction with [this] individual. It keeps recurring. He's like drawing a line in the sand, it keeps happening. It hasn't happened with the intensity or the frequency in the last four or five years. It probably was more so in the earlier years.

Not that I knew of [bad outcomes], just more issues of management I think. Who's to be managing this? I think in one case it [the style of management] was different, but in many cases it's not radically different. It's like who's in charge, it's like turf. It's like when the nurses complain to the obstetrical attending that she doesn't feel comfortable with the way this patient's being managed and that has happened on various occasions. This [obstetrical resident] was a lot of respect [to the OB], nursing staff and that's been a repetitive role... we've gotten blown and they've got involved, and how we've gotten from there.

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