PRACTICE, EDUCATION, WORK AND SOCIETY

Health Practice Relationships

Joy Higgs, Anne Croker, Diane Tasker,
Jill Hummell and Narelle Patton (Eds.)

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HEALTH PRACTICE RELATIONSHIPS

PRACTICE, EDUCATION, WORK AND SOCIETY

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Health Practice Relationships

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JOY HIGGS

SERIES INTRODUCTION

Practice, Education, Work and Society

This series examines research, theory and practice in the context of university education, professional practice, work and society. The series explores spaces where two or more of these arenas come together. Themes that are explored in the series include: university education of professions, society expectations of professional practice, professional practice workplaces and strategies for investigating each of these areas. There are many challenges facing researchers, educators, practitioners and students in today's practice worlds. The authors in this series bring a wealth of practice wisdom and experience to examine these issues, share their practice knowledge, report research into strategies that address these challenges, share approaches to working and learning and raise yet more questions. The conversations conducted in the series will contribute to expanding the discourse around the way people encounter and experience practice, education, work and society.

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FOREWORD

Health practice is about the provision of human services to people who are seeking enhanced wellbeing. In this book we place the human dimension of relationships at the centre of our discussion of healthcare and portray these relationships in the contexts of professionalism and healthcare operating systems. In the current context of healthcare and of societies that are facing global financial and population pressures, the imperatives of funding and organising systems can conflict with people's needs for humanity as well as technical competence in their healthcare experiences.

This book illuminates and challenges professional healthcare relationships. The authors examine the nature, context and purpose of healthcare relationships, explore models through which these relationships are enacted, developed and critiqued, and provide narratives of health practice relationships in action. These narratives reveal how relationships are experienced and created in real-world situations. The discussions generate a range of implications and recommendations for healthcare practice and systems and for the education of health professionals. This book is addressed to practitioners, educators, clients, members of the community, advocacy and agency groups, regulatory bodies and those with power to shape the future direction of healthcare. There are four sections in the book:

Section 1: Health practice relationships context

Section 2: Understanding professional relationships

Section 3: Health practice relationships narratives

Section 4: Implications for practice, systems and education

Joy Higgs

SECTION 1: HEALTH PRACTICE RELATIONSHIPS CONTEXT

JOY HIGGS

1. HEALTH PRACTICE RELATIONSHIPS

This book, and this chapter, explore health practice relationships. This chapter sets the scene for the book and privileges the humanity and diversity of social and practice relationships that this title evokes. In Chapter 2 we turn to the topic of professional practice, placing this book predominantly in the context of Western orthodox medicine today, and we place the clients, support people and healthcare providers at the centre of our discussion. Here, however, it is valuable to acknowledge the broader interpretation of health as the pursuit of wellbeing, of healthcare as ranging from self-managed healthy living to alternative medicine, traditional healing, and Eastern medical practices, as well as contemporary Western orthodox medicine. Across these frames of reference and practices of healthcare, relationships between people – receivers and agents, clients and providers, health seekers and health practitioners, patients and carers, individuals and service agencies, colleagues, practitioners and clients, with translators, advocates, volunteers, support personnel, religious staff – play a fundamental role in the experience and outcomes of healthcare for those involved and for those concerned about enacting and embodying person-centred care.

PRACTICE

Practice encompasses the doing, knowing, being and becoming of professional practitioners' roles and activities (Higgs, 1999; Higgs & Titchen, 2001); these activities occur within the social relationships of the practice context, the discourse of the practice and the practice system, and the setting (local and wider) that comprise the practice world. Relationships in health practice occur throughout each of these embodied activities. These relationships translate our worldview and our being, or practice ontology, into the way we frame our models or frameworks for practice. They enable the doing or realisation (making real) of the pursuit of wellbeing by practitioners, clients and agencies. They bring self as interactive agent into who we are and what we do as participants in healthcare collaborations. They challenge what we know, what we are learning, how we derive knowledge from practice and what knowledge growth we want to pursue. These things comprise our practice epistemology. They shape how we reflect upon ourselves and grow in practice, communication and engagement; both how we want to practise (our practice model aspirations) and who we want to become, which includes developing a practice model and identity. Doing, knowing, being and becoming in practice are, simply, not solo and self-focused pursuits. Titchen and Higgs (2001, p. 269) emphasised

J. Higgs et al. (Eds.), Health Practice Relationships, 3–8.

> the inseparability of self and professional role and indeed, the desirability of their integration, both for the enhancement of the service that professionals provide and for the enrichment of their own journeys. … We recognise the importance of understanding and acknowledging self as part of employing a critical social framework for professional practice. Self-knowledge is a precursor to achieving the goal of transforming self and helping others to empower themselves.

CONTEXTUALISING HEALTH PRACTICE RELATIONSHIPS

The context of healthcare and relationships in health practice is shaped by historical, social and cultural influences (see Chapter 2). The particular contexts that were selected for this book and which have emerged through the collaborations with co-authors and clients include the following.

In section one the authors examine the following health practice relationship contexts: professional practice, healthcare systems and spaces, changing directions in healthcare, and the important place and practice of patient-centred care. We see in these chapters that healthcare practice is a complex and dynamic space that requires understanding and making choices about the stances we want to take and the way we want to relate to others. Section two deals with understanding professional relationships. In this section readers are asked to consider the changing face of professionalism and what this means to healthcare practice and relationships and the challenges associated with working in teams and negotiating healthcare relationships. Alongside these challenges, questions are raised about how healthcare participants collaborate and demonstrate caring for others. All these endeavours are overlaid by our own aspirations and the expectations of healthcare consumers and systems in relation to access, agency and quality of care.

A range of narratives is provided in section three, bringing the reader inside the experiences of health practice relationships. Voices in this section include mothers of children with disability, people with chronic illnesses receiving healthcare in their homes, students and educators in clinical education, family members, people with mental health concerns, Indigenous practitioners and communities, patients, educators, practitioners and students. Various settings and relationship modes are explored, including person-centred, care, interprofessional collaboration, rural contexts, situations where people need to make decisions for others, training wards, and long-term patient-student relationships. In the final section the themes of the book are tied together in interpretations around the themes of relationships, systems and professional education. Readers will also have their own realisations and issues to ponder.

PRACTICE RELATIONSHIPS

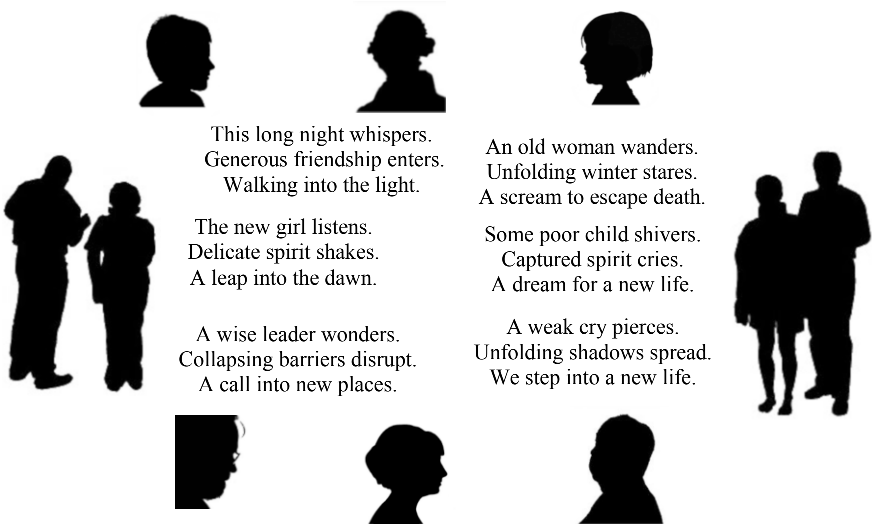
We typically think of relationships as personal connections, sometimes chosen, sometimes inherited, sometimes successful, sometimes problematic, but they are where we belong or where we are. What happens when practitioners and clients enter a practice relationship?

Traditionally, practice relationships were "clinical" – objective, dispassionate, regulated. They gained value through service, professionalism and ethical conduct. For our patients healthcare was provided; the patient's role was to comply with the highly educated, professional advice provided.

And what of today? Is the power gap still there – in knowledge, in decision making, in action and agency? What "distance" should practitioners keep? What are their roles in the new era? How do they cope with changing client interests? What choice does the client want? Who else is part of the scene? Are clients – universally – more educated, more informed, more capable of shared decision making, of managing their own healthcare? Can they all speak on their own behalf? Can they take agency in their own care? So, what are today's health practice relationships like? They are multi-hued and multi-faceted; with as many variations and complexities as the people who participate in these professional practice relationships.

PARTICIPANT VOICES AND CHALLENGES

Consider the range of people who participate in healthcare practice. What are their roles, needs, interests and capabilities as agents of participation? What are their voices saying – what do we need to hear? The graphic below includes Haiku poems. This form of a short poem, originally developed by Japanese poets, uses sensory language to capture an image or feeling. Haiku are often inspired by a poignant experience, an element of nature or a moment of beauty. These reflections capture critical aspects of relationships: entry points, human needs, uncertainties, hopes and fears.



This long night whispers.
Generous friendship enters.
Walking into the light.

The new girl listens.
Delicate spirit shakes.
A leap into the dawn.

A wise leader wonders.
Collapsing barriers disrupt.
A call into new places.

An old woman wanders.
Unfolding winter stares.
A scream to escape death.

Some poor child shivers.
Captured spirit cries.
A dream for a new life.

A weak cry pierces.
Unfolding shadows spread.
We step into a new life.

Across these many voices, lives and situations, different people over a wide range are engaged in the spaces and relationships of healthcare. Each person entering into these spaces is caught up in "person-meets-system", "choices-versus-expectations", and "my needs and theirs", mixed up with all the complexities of the pursuit of health and dealing with illnesses and human frailties.

For practitioners, relationships with colleagues and clients are part of their professional responsibilities and thus need to occur broadly in a socially responsible and accountable manner as well as specifically within the code of conduct of their profession (professional ethics) and the expectations of the workplace or organisation (e.g. an organisational charter).

> For over 2,000 years, it was not thought necessary to actively teach professionalism. The ideals and values of the (medical) profession were transmitted by mentors and role models and were important components of the tacit knowledge base of physicians. … (However) the professionalism of yesteryear has difficulty in coping with contemporary funding and regulatory mechanisms and with a society that has also changed profoundly. (Cruess, Cruess, & Steinert, 2008, p. 2)

A key challenge for today's practitioners is learning about the reality of professionalism on the job. They need to learn about issues and practicalities of ethics, codes of conduct, professionalism, risk management, self-preservation, bringing self into practice, litigation, self- and external regulation, institutional cultures and regulations, and working in healthcare teams within and outside the institution. And this learning is complicated by the changing worlds of practice, systems management, community profiles and cultural mixes and clients' expectations. Learning in academic settings is not sufficient to engender these understandings and capabilities. Instead, real-world experiences (or workplace learning) with real-world and real-life consequences are needed to bridge the reality gap for students and best prepare them for practice. Ideally, workplace learning is embedded into the curriculum and blended with other pedagogies including simulated learning, pre- and post-workplace learning preparation and debriefing, and online learning.

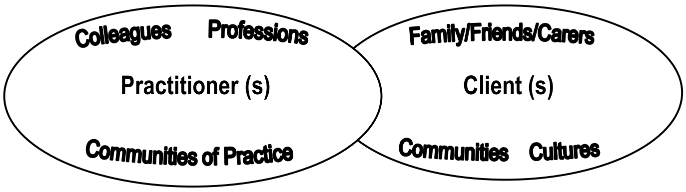
Whether pre-entry, continuing, informal or self-directed, education plays an important part in helping practitioners face these challenges. While it is not possible for formal professional education to anticipate every learning need for every person, it is important for education to address the difficult as well as the more straightforward challenges of preparation for professional practice. Courses need to help prospective practitioners to understand professionalism, to develop capabilities to face – or at least to learn how to develop capabilities to face – the demands of practice and practice relationships, and to forge a professional identity that is both a starting point to carve out a career of professional service and accountability and the realisation that this identity will inevitably change across their careers.

Kemmis (2010) wrote about the complexity of professional practice and recognised the importance of patients in professional practice. He contended that patients were “not merely ‘objects’ operated on or influenced by practitioners, but persons-in-themselves who are, to a greater or lesser degree, knowing subjects who are co-participants in practice” (p. 145).

What challenges face patients or clients in practice relationships? In part, this depends upon the state of their health. Ill health in acute and in long-term situations can diminish agency and place people at the mercy of empowered systems and practitioners. Sometime the pursuit of better health and the courage to take responsibility and initiatives can bring about self-empowerment. However, this is often a double battle, both for inner strength and for resilience to stand up against system controls that may serve to diminish that strength.

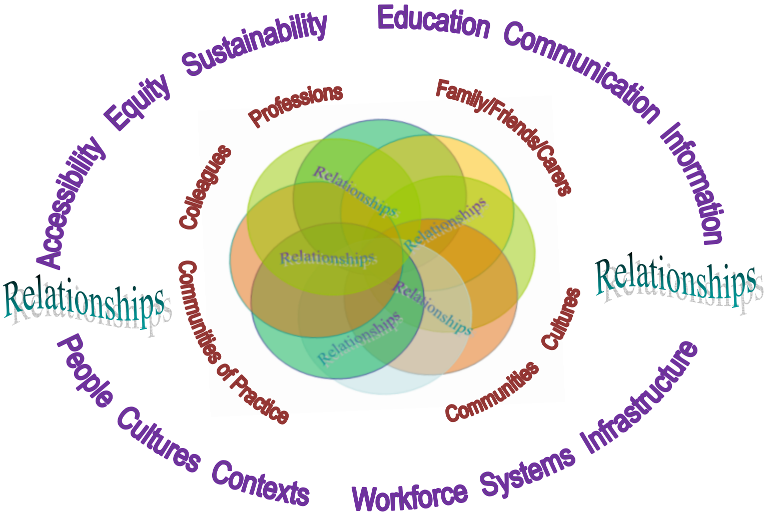
A MODEL FOR HEALTH PRACTICE RELATIONSHIPS

A model for health practice relationships starts with the key players, operating within their individual frames of reference, cultures and communities of practice and forming relationships that bring these frames of reference into dialogue.



Next, consider how these relationships overlap and each person becomes part of multiple relationships. People take their perspectives and personal relationships into these health practice relationships.

Next, we need to recognise the multiple contextual factors (the outer ring below) that influence our many health practice relationships.



CONCLUSION

All around the participants in healthcare, the world of practice is changing at an unprecedented rate. Within practice, relationships form the core. This is not in question. Rather, in this book we question how these relationships can and should develop, and we consider links between "healthy" practice relationships and sustainable practice futures for healthcare practitioners.

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2. PROFESSIONAL PRACTICE

Professional practice is a social phenomenon in essence and in realisation. How we view professional practice in any era is influenced by the sociocultural and historical influences on that era. “There is no single, ahistorical set of professional practices” (Broadbent, Dietrich, & Roberts, 2005, p. 1). Contextual change is dynamic rather than linear, embedded rather than objective, conditional rather than predictable, and is amenable to influence rather than inevitable.

Social constructionists hold that the way we experience everything is shaped by personal, historical and cultural influences (Gergen, 2009). The term *social constructionism* was introduced by Berger and Luckmann (1966), building on the work of Schütz. Schütz (1964, 1967, 1970) was concerned with the social world, specifically the social nature of knowledge. He argued that, within the “life world”, people create social reality and are also constrained by the existing social and cultural factors and structures they inherit from previous generations.

Social constructionism refers to a theory of knowledge in sociology and communication theory; it proposes that knowledge is not individually generated but is created collectively as a result of the fluid, subjective and relative nature of our interpersonal processes (Schwandt, 2001). In this theory, people interacting in social systems co-create meaning and knowledge. This meaning-making process involves people using language as the core system of constructing reality, and creating a model of the social world to make sense of their experiences (Leeds-Hurwitz, 2009). Through shared understandings, members of society develop habitual, reciprocal roles that embed meaning in society and construct social reality.

ORIGINS AND EVOLUTION

In essence, the word *profession* refers to the idea of professing or declaring publicly, which was linked to taking solemn vows on entering a religious order (c.1200, Middle English) and went on to be associated with an occupation one professes to be skilled in, and a body of people engaged in an occupation. The word is derived from Latin *professio* from *profitēri* (declare publicly).[i]

In medieval times three professions, the “learned professions”, were recognised by society: medicine, law and divinity. Of interest is the evolution from society’s need (e.g. for law), to practices (e.g. in using laws), to recognised practitioners, then to occupations which through professionalisation emerged into professions. Brundage (2008) examined the history of Roman law in antiquity and identified the development of a legal profession in the last two centuries of the Roman republic. This was preceded by laws existing in many civilisations including Ancient Egypt

J. Higgs et al. (Eds.), Health Practice Relationships, 9–16.

(3000BC). Medicine, including the use of herbal remedies, existed in prehistory and was practised in an advanced form by the ancient Egyptians and ancient Greeks and in both India and China (Metcalfe, 2007). Religious leadership was born in prehistory and the study of theology was part of ancient academies as far back as the Platonic Academy founded in Athens in the 4th century BC (Morgan, 2010).

Hamilton (1951, p. 141) described two important developments occurring in medicine in the 1700s: a revolution in science and training, and "a growth of professional feeling, which led to a struggle for improved status and for reform of the profession". She contended that these two movements, along with the significant expansion of the middle classes, meant that "by 1800 the professional scene of a hundred years before had been completely transformed: the apothecaries, once mere tradesmen and the "servants of the physician", had become practising doctors; the surgeons had dissociated themselves from the barbers, and the "pure" or hospital surgeon had become a specialist of high reputation (p. 141). What emerged was a professional class replacing the distinction between gentleman physicians and the craftsmen apothecaries and surgeons. As a result of these changes, "professional honour, etiquette and status were now matters of the liveliest debate" (p. 141). We discuss issues of ethics and professional conduct below.

From these earlier days the rise of professions as occupational groups has escalated, particularly from the 20th century, in terms of the number of professions, the percentage of professions in the workforce, and the influence of the professions in society leadership and governments (Saks, 2013). Today, society recognises many professions across a range of fields including education (academics and teachers), commerce (accountants, actuaries, economists), healthcare (doctors, dentists, allied health professionals, nurses), the social and justice services (lawyers, psychologists, social workers), the construction industries (urban planners, surveyors, engineers) and religion (clergymen).

RECENT CHALLENGES TO THE PROFESSIONS

In recent years, questioning of the future of the professions has become a regular occurrence. Broadbent et al. (2005, p. 1) observed, "we are all facing and coping with … the stresses and contradictions of changing work and organisational practices. … and we are in the course of developing new understandings of what is meant by the term professionalism". They cautioned that we need to understand the dynamics of change rather than assume we can deal with the messiness and uncertainties of our changing world using intuition and common sense. The authors in their edited volume argue that the restructuring of professional work encompasses:

- adopting a fundamental rationale for professionalism that means the professional organisation might evolve and blur but that it cannot be viewed as an optional extra in society

- seeing professionalism as a diverse set of practices grounded in the contexts of different professions and informal norms grounded in society norms as well as explicit rules; professionalism is subtle and complex and should not be oversimplified
- recognising both the common roots and the diversity in professionalism in order to understand the current change era
- recognising the dynamism of the current era and the historical location of the set of institutional practices that requires change agents.

Within today's economic, technological and organisational trends (Fournier, 2000), developments such as market liberalism and commercialism challenge the foundations and legitimacy of the professions. The impact of these changes is evident in blurring boundaries between different professions, for instance, through multi-functional teamwork in the search of the flexibility deemed requisite for the turbulent environments of work and the commodification of professional labour. Similarly, boundaries between managers and professionals are becoming blurred in the pursuit of entrepreneurial opportunities. Increasing external and institutional demands for accountability have resulted in less attention to individual accountability and personal responsibility for quality of care and professional conduct. With the increasing availability of Internet information, clients are becoming empowered consumers and, at the same time, they face escalating costs for professional services. This has led to clients questioning professional advice and decisions and seeking value for money. The authority, mystery and monopolies of the professions have been challenged, and professions face declining respect and status. Professionals have been challenged for their increasing self-interest over public interest (Saks, 2013). The present context of the professions is one of contradictions and paradoxes, and their future robustness remains to be seen. We await the next phase of the confrontation of market-economy and expert-disseminated knowledge.

Key questions raised in this challenge to the professions are, "Why should there be occupational groups controlling expert knowledge?" and "Will professionalism spread throughout the occupational world?" In answering such questions, Abbott (1988) conducted a historical comparative study of the system of professions as a whole. He identified the important concept of jurisdiction, or the link between an occupation and its work, and the way professions are interdependent and occupy a space of contested jurisdictions. He argued that the division of labour in society creates the need for an expert division.

Beck and Young (2005) drew on Bernstein's (2000) interpretation of how particular knowledge structurings may be related to the formation of occupational identities through what Bernstein referred to as "inner dedication" and "inwardness". Challenges to these identities come from genericism and the regionalisation of knowledge. Beck and Young contended that, beyond "mere criticism", the recent challenges facing the professions have resulted in the radical restructuring of professional practice by governments and by marketisation. They reflected on the profound consequence of these changes and influence for professionals, particularly in terms of their relationship to knowledge, clients and organisational structures.

PROFESSIONS AND THEIR CHARACTERISTICS

In general usage the term *profession* has many connotations, ranging from a highly specialised and skilled occupation to any full-time paid job (Freidson, 1986). In the context of this book we refer to professions that are recognised as such by society. Interpretations and definitions of established professions as a social construct vary considerably. A profession is:

> an occupation that regulates itself through systematic, required training and collegial discipline; that has a base technical specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics. (Star, 1982, cited in Cruess & Cruess, 2008, p. 1)
>
> an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice, and the privilege of self-regulation. Professions and their members are accountable to those served, to the profession, and to society. (Oxford English Dictionary, 1989)
>
> a self-regulated occupational group having a body of knowledge, an inherent culture and a recognised role in serving society. Professions operate under continual scrutiny and development, and are self-regulated, accountable, and guided by a code of ethical conduct in practice decisions and actions. Membership of a profession requires completion of an appropriate (commonly degree-based) intensive educational program. (Higgs, Hummell, & Roe-Shaw, 2008, p. 58)

Most definitions of professions refer to the following characteristics: a specific knowledge base, a service orientation, formal education and a code of ethics. More complex definitions also include advanced features such as culture, professional evolution and professional status being a social contract with society.

Recognised, established professions arise when an occupation transforms itself through “the development of formal qualifications based upon education, apprenticeship, and examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights” (Bullock &

Trombley, 1999, p. 689). According to Perks (1993), the major milestones that may mark the identification of an occupation as a profession include:

1. an occupation becomes a full-time occupation
2. the establishment of a training school
3. the establishment of a university school
4. the establishment of a local association
5. the establishment of a national association
6. the introduction of codes of professional ethics
7. the establishment of state licensing laws.

PROFESSIONAL PRACTICE

Building on the above discussion, we now turn to a reflection on professional practice. According to practice theory, “practice is [seen as] an organised constellation of different people’s activities. A practice is a social phenomenon in the sense that it embraces multiple people. The activities that compose it, moreover, are organised” (Schatzki, 2012, p. 13). Activity “is the idea that important features of human life must be understood as forms of, or as rooted in, human activity – not the activity of individuals, but in practices, that is, in the organised activities of multiple people” (Schatzki, 2012, p. 13). Practices prefigure individual actions (Schatzki, 2002).

> The term practice can refer broadly to social practice, and more precisely, it frequently denotes professional practice. Practice is inherently situated and temporally located in local settings, lifeworlds and systems; it is embodied, agential, socially-historically constructed and it is grounded and released in metaphor, interpretation and narrative. Practice models come in many shapes and forms: technical-rational, empirico-analytical, evidence-based, interpretive, and critical emancipatory models, for example. In action, practice, can be collective (e.g. a profession’s practice) and individual (such as an individual practitioner’s practice). A (collective) practice comprises ritual, social interactions, language, discourse, thinking and decision making, technical skills, identity, knowledge, and practice wisdom, framed and contested by interests, practice philosophy, regulations, practice cultures, ethical standards, codes of conduct and societal expectations. An individual’s practice model and enacted practice are framed by the views of the practice community as well as the practitioner’s interests, preferences, experiences, perspectives, meaning making, presuppositions and practice philosophy. (Higgs, 2012, p. 75)

Enacted Professional Practice

Professional practice can be interpreted as “the enactment of the role of a profession or occupational group in serving or contributing to society” (Higgs, McAllister, & Whiteford, 2009, p. 108). The term *practices* refers to customary activities associated with a profession, and to the chosen ways individual practitioners implement their practice/profession. Examples of practices are ethical conduct, professional decision making, client-practitioner communication, consultation and referral, and interdisciplinary teamwork (Higgs, 2012). As we explore this book on relationships in health practices, an important lens to facilitate the reflection on challenges faced by those enacting and embodying professional practice is to see how these practice expectations are addressed and how they are re-created in the changing context portrayed above.

Communities of Practice

Consistent with the previous discussion that highlighted the inherent social nature of both professions and professional practice, we now focus on the central role of practice communities to the development of practice capabilities and practice identity. In their landmark work on situated learning, Lave and Wenger (1991) articulated a model of workplace learning in which development of practice capabilities unfolds in opportunities for practice. In this model, practice capabilities are developed through the process of becoming a full participant within a community of practice. Communities of practice have been defined broadly as groups of people who share a concern, a set of problems, and a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger, McDermott, & Snyder, 2002). This model highlights participation, social interaction, and consequently relationships as key features contributing to the successful development of practice capabilities and practice communities in workplace contexts.

Health practitioners are active participants in social (professional) communities, constructing their identities in relation to those communities, with participation shaping not only what they do but also who they are and also how they interpret what they do (Wenger, 1998). A community of practice shares existing knowledge and provides an arena for the development of new knowledge and transformation both of practitioners (Candy & Mathews, 1998) and communities (Ranse & Grealish, 2007). Effective participation in supportive communities of practice supports the development of health practitioners as effective team players capable of forming meaningful professional relationships and engaging in collaborative problem solving (see Baldry Currens & Coyle, 2013).

Development of practice capabilities can thus be understood as both an embodied process (through action) and an embedded process (in practice communities), with transformative potential for both learners and communities. This is important because it highlights the importance of social interaction to transformation of the practice(s) of both individual practitioners and practice communities. In this way, health practice relationships play a central role in the formation of individual practitioners and practice communities capable of meeting the complex and fluid demands of 21st century health practitioner practice.

CONCLUSION

This chapter has presented professionalism and professional practice as a mixture of known, familiar expectations and practices, alongside major challenges from society (local and global), knowledge and technology dynamics, profession–workforce tensions, and organisational and system responses. We have sought to provide a backdrop against which professional practice relationships can be examined and illuminated. How these relationships react, suffer or triumph is the subject of the stories and analyses in this book.

NOTE

[i] http://www.etymonline.com/index.php?term=profession

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3. HEALTHCARE SYSTEMS AND SPACES

“We need to discuss healthcare”, proposed the *health policy maker.*
Those listening welcomed the statement. They nodded in agreement,
each confident of their grasp of the implications.
“OK”, thought the *health manager*,
“let’s explore how to target our health strategies more efficiently,
focus on measurable outcomes and get better value for the dollar”.
“Wonderful”, concurred the *doctor*, “and we need to make sure
our practice is founded on the best scientific evidence”.
“Do you think”, wondered the *social worker*, “that we can include
strategies for the social factors influencing health?”
“This has potential”, speculated the *complementary, alternative health practitioner*,
“maybe we can widen the focus from illness to wellness”.
“Maybe”, sighed the *patient* to the *carer*, “they will listen
to what it is like to be treated for this condition”.

Healthcare is a broad yet heterogeneous notion that can be viewed in different ways. On one hand, healthcare is a service industry with major employer status, high expenditure and rapid growth. As a service industry healthcare tends to be objectified as a set of efficient, reproducible, measurable *systems.* On the other hand, healthcare encompasses a range of human relational experiences. These experiences draw on and reflect people’s various situations, perspectives, needs, fears and aspirations, as healthcare providers, patients, clients, consumers and carers. In contrast to the notion of systems that characterises healthcare in abstract and instrumental terms, people’s experiences occupy and define the *spaces* where healthcare is delivered and received. In this chapter we invite readers to reflect on the notion of healthcare, not just in relation to the complexity of healthcare systems, but also in relation to the human-richness of the spaces where specific and unique health practice relationships are enacted and experienced.

DIVERSE UNDERSTANDINGS OF HEALTHCARE

The healthcare arena is full of diverse understandings of health and various conceptualisations of healthcare. These understandings and conceptualisations shape how healthcare is provided and experienced. For example, the different *illness, wellness, environmental* and *relational* models of healthcare shown in Table 3.1 involve different people with various roles: health professionals, complementary and alternative health practitioners, family members, managers, bureaucrats, politicians and engineers. The range of people, roles and strategies involved highlights the scope of healthcare and the potential for healthcare to permeate so many aspects of daily life and community.

J. Higgs et al. (Eds.), Health Practice Relationships, 17–26.

Table 3.1. Different models of healthcare

Model focus linked to meanings of health shaping the provision of healthcare	**People providing healthcare**
Illness (or *biomedical*) model based on a view of health as the absence of disease or disability	Health professionals providing healthcare, for acute and chronic conditions, and rehabilitation People undertaking self-medication and helping others (such as friends and family) manage disease and illness
Wellbeing model based on health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'" (WHO, 1946)	Health professionals involved in health promotion and preventive health strategies People making healthy choices and assisting others (such as friends and family) with their healthy choices Complementary and alternative health practitioners (such as naturopaths, osteopaths, chiropractors and spiritual healers) providing healthcare that lies outside mainstream medical practices
Environmental model founded on four elements: human biology, environment, lifestyle and healthcare organisation (based on Lalonde, 1981)	Health professionals working to implement public health strategies Other scientific professionals such as environmental scientists and engineers Non-professional strategists and lobbyists
Relational model based on care as interpersonal dynamic realised through *in situ* interaction, affect and emergent activity	Anyone with a role in health service organisations and with influence over the quality of the carer-service user relationship acknowledging that the quality of the relationship is critical to the clinical-technical outcomes of the service encounter

Models for healthcare are not mutually exclusive, nor are boundaries between them clear cut or static. People may use therapeutic options from a range of models; for example, a person with back pain may self-medicate, consult a medical specialist and visit an osteopath. Some health problems require contributions from several healthcare models. A child with diabetes may require daily injections of insulin, family members may assist with control of blood sugar levels by appropriate food choices, community members may lobby for healthy school canteens, and health professionals may facilitate ongoing relationships with the child and family.

Patients increasingly see complementary and alternative medicines as important options for a number of health problems. These options tend to be used by those who are dissatisfied with aspects of the illness model of healthcare, including health professionals' time pressures and poor communication skills (Bishop & Lewith, 2007). For its part, patients' satisfaction about the relational dimensions of their care relationship has now been shown to have a critical bearing on their healing (Boulding, Glickman, Manary, Schulman, & Staelin, 2011) and on the safety of their care more generally (Greaves, Ramirez-Cano, Millett, Darzi, & Donaldson, 2013).

The roles of people involved in healthcare are similarly interrelated and dynamic. Healthcare professionals are *people* who bring their socialised health professional perspectives and personal understandings to their work and to their relationships with patients and colleagues. Career choice for some healthcare providers is based on personal experience with their own health issues or family members' careers in health. Further, they are all healthcare users, sometimes not through choice; illness can be thrust upon them.

While models of healthcare and different viewpoints within these models have the potential to contribute to a rich diversity they can also impede shared purpose in the provision of healthcare and can challenge open communication. People working in health need to recognise the value and limitations of their understandings in relation to the perspectives of others. For example (in relation to the quotes at the beginning of the chapter), targeting health strategies with explicit outcomes such as morbidity or mortality favours an illness rather than a wellbeing model of healthcare; and focusing on scientific evidence can overshadow lived experiences of health and illness. By implication, the practice of framing healthcare in systemic and similarly abstract and numerical terms can downplay the significance of the spatial perspective; that is, one promoting concern with how healthcare is enacted in particular places, and by and for particular people.

In the following sections we first describe the healthcare systems that are at the centre of our discussion: those of Australia and New Zealand. Zooming in to what happens "on the ground", we then turn to consider the spaces where the rubber of these systems "hits the road" of tangible care. Here, we bring healthcare into focus as a generally uneven and constantly reconfiguring dynamic.

NATURE OF AUSTRALIAN AND NEW ZEALAND HEALTHCARE SYSTEMS

Within the vast scope of healthcare meanings and models are the legislated healthcare systems under government control. These systems provide an explicit framework for systematically implementing decisions related to the models of health that are funded and controlled, and how resources are allocated accordingly: that is, who has access, what they have access to, where they can access it, how much it costs and who pays.

The legislated healthcare systems of Australia and New Zealand are financially well-resourced, complex systems where credentialed health professionals have the dominant role in providing regulated healthcare. These healthcare systems are the main focus of this section. The largest proportion of funding in the Australian and New Zealand legislated healthcare systems is allocated to inpatient acute care (based on French, Old, & Healy, 2001; Healy, Sharman, & Lokuge, 2006). Although an illness (or biomedical) view of health dominates, the value of other models of healthcare is increasingly recognised and funded. Healthcare systems in these countries are also interlinked with aged care and disability services, as patients are required to move between and negotiate different structures and processes. While housing, employment, justice and education also impact on health, these areas tend to be beyond the control of healthcare policies and services.

Governance of Healthcare Systems

Common to both Australia and New Zealand is the aim for universal healthcare, networked governance of the healthcare system and multiple funding sources. Differences in the healthcare systems are evident, however, particularly in relation to the number of different tiers of government funding, with New Zealand avoiding the added complexity of federal and state funding splits.

The aim of Australia's national healthcare system is to give all Australians "access to adequate health care at an affordable cost or no cost" (Australian Institute of Health and Welfare, 2012, p. 18). The overarching responsibility for health policy direction and regulation of health professionals lies with the Commonwealth Government. Separate state and territory governments are predominantly responsible for funding and delivering healthcare services, with local governments playing a supporting role in providing community health services (Australian Institute of Health and Welfare, 2012). Across these different levels of responsibility, a number of healthcare services are either provided free of charge or subsidised through the taxation funded system of Medicare. Complementing these publicly funded services are private services supported by a range of insurance schemes. Compensation for healthcare costs related to motor vehicle accidents and workplace incidents is through compulsory insurance purchased by vehicle owners and employers respectively. As a result of fragmented healthcare services and specific projects administrated and funded by different tiers of government, as well as private and non-government enterprises, the Australian healthcare system is characterised by overlapping responsibilities, cost shifting and disparate health records. These internal differentiations require health professionals to work across departments and agencies, and can pose problems for patients moving between different healthcare facilities.

New Zealand healthcare systems are less differentiated than the Australian, but nevertheless complex. Healthcare policy is the domain of government, with health service delivery operationalised by District Health Boards (DHBs). Governed by an elected board, these DHBs plan, manage, provide and purchase health services for the population of their district, with the aim of ensuring effective and efficient services for all New Zealand (Ministry of Health, 2012). DHBs are responsible for funding decisions related to primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Māori and Pacific providers. New Zealand is unique globally in that the Accident Compensation Corporation (ACC) funds injury (work, sport, road accident or medical error). This has reduced the impact of private insurers as indirect funders of healthcare and reduced litigation. While the presence of ACC in the New Zealand Healthcare system has ensured that access to urgent treatment for injury is available and funded, it can also result in disparity. For example, individuals needing orthopaedic surgery due to an accident do not face the same long waiting lists as those requiring hip replacements due to osteoarthritis.

Responsive Strategies

Within both the Australian and New Zealand healthcare systems, strategies have been developed to respond to the needs of groups of people, address particular health conditions and shape the services provided. Of particular importance are specific projects that address health needs in at-risk communities. In Australia, Aboriginal and Torres Strait Islander people experience disproportionally high levels of poor health and are in particular need of such specially funded projects (Australian Institute of Health and Welfare, 2012). The "Close the Gap" campaign is an example of a nationally funded government project aimed at reducing "indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement and employment outcomes" (Australian Indigenous Health *InfoNet*, 2010). The interrelated building blocks of this project are based on a holistic view of health and address early childhood, schooling, health, economic participation, health homes, safe communities, and governance and leadership (Australian Indigenous Health InfoNet, 2010).

Consistent disparities exist between the health status of Māori and non-Māori New Zealanders (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Ministry of Health & University of Otago, 2006). Evidence repeatedly shows that Māori receive lower levels of health services and poorer quality of service. New Zealand's Whānau ora, jointly implemented by the Ministry of Māori Development and the Ministries of Social Development and Health, is the latest example of an alternative approach to the delivery of healthcare based on a Māori view of health. This approach assumes that changes in an individual's wellbeing can occur by focusing on the family collective and vice versa. In supporting families within the community context rather than individuals within an institutional context, Whānau ora requires multiple government agencies to work together.

Responsive strategies also enable particular burdens of illness to be addressed. For example, people with cardiovascular conditions and diabetes are targeted through national health priorities. Efficient healthcare practices are encouraged through strategies such as shorter waiting times in emergency departments, and workforce issues are addressed through a range of approaches, including trialling the use of physician assistants to provide supervised healthcare in areas of need. While such strategies enable healthcare systems to respond to the diverse needs of patients and healthcare service providers, they potentially add another layer of complexity to relationships within healthcare systems. For example, the target for 95% of patients being discharged from emergency departments in New Zealand within 6 hours and in Australia within 4 hours can affect staff relationships with other areas of the hospital that may be pressured to discharge patients under their care to ensure beds for patients admitted from the emergency department. Similarly, with the introduction of physician assistants, health profession roles and health professionals' interactions may need to be re-negotiated.

Quality in Healthcare

A key aim of New Zealand's Health Quality & Safety Commission, established under the New Zealand Public Health and Disability Amendment Act 2010, is to improve the quality, safety and experience of healthcare and disability services. While the Australian Commission on Safety and Quality in Health Care (ACSQHC), an independent statutory authority under the National Health Reform Act 2011, provides similar direction to healthcare services and the people working within them, the disability sector is outside its scope.

Inherent within the mandates of these organisations is a humanistic stance that seeks to involve patients in their healthcare and facilitate optimal experience of the healthcare system. Patient-centred practice, shared decision making and consumer engagement are encouraged. For example, the recent Australian Quality and Safety Standards promote patient engagement in healthcare decision making at various levels (Australian Commission on Safety and Quality in Health Care, 2012). However the challenges of such practices are acknowledged:

> ACSQHC is aware that while there is wide and strong commitment to a healthcare system that is focused on the needs of patients and consumers, health services and health service providers can struggle with enacting the principles of patient centred care in practice. (Australian Commission on Safety and Quality in Health Care, 2013)

As part of ensuring quality in healthcare, health professionals are required to work within sets of interconnected obligations and expectations, including professional registration regulations, professional association and organisation codes of conduct, and legal requirements. To address these expectations, courses are accredited, individual practitioners are registered, and ethical conduct is monitored. The Australian Health Practitioner Regulation Authority (AHPRA) and New Zealand's Professional Registration Boards, established under the Health Practitioner Regulation National Law (2010) and the Health Professional Competency Act (2003) respectively, are responsible for health professional registration and community concerns about health professionals' conduct. However, in a healthcare context that is increasingly interested in health professionals working together, the discipline-specific focus inherent in credentialing and registration has the potential to overshadow the development of interprofessional collaborative practice.

Healthcare Education Integrated with Healthcare Service Provision

The Australian and New Zealand healthcare systems play significant roles in the education of health professionals. Much of the education within health services relies on the goodwill and professionalism of experienced practitioners who often undertake unpaid educator and supervisory roles for student clinical placements and graduate professional development. Beyond these educational roles are specialist qualifications obtained while working within healthcare institutions. For example, doctors employed by a healthcare facility may undertake medical specialty vocational training that has been accredited by the appropriate discipline body.

Despite the healthcare system's important role in educating health professionals, there is a paucity of formal targets or performance goals to support and resource such clinically based education. In consequence, the education of health professionals risks relying on a network of relationships that is beyond the view of healthcare managers and policy makers. This network may face future challenges, particularly with increasing student numbers and escalating demands for student placements.

COMPLEXITY OF HEALTHCARE SPACES

Moving the focus of the chapter from *healthcare systems* to *healthcare spaces* enables us to embrace the *in situ* human relational experiences of healthcare. Here we can explore the places where structure, policy, practice and people interact and where they manifest as tangible care. While the predominant concern in health policy making, healthcare practice improvement and health service research is with the general systems of care, patients and their families and carers experience *care* as a dynamic that unfolds in specific spaces and unique places.

For patients, their families and carers, the impressions left by the care they receive tend to include feelings about the size, colour and content of the room, the ways in which healthcare workers (health professionals and others in supporting roles) have to navigate past one another in order to get their tasks done, and the impact of these environmental constraints on how and whether people are effective in their roles and functions. Other things that might stand out are the strategies adopted by healthcare workers for creating boundaries around their work in order to keep it safe – for example, taking time out to "catch their breath", and treading carefully round or even avoiding particular patients or colleagues.

Importantly, considering healthcare from the perspective of space foregrounds the dynamic complexity of how care unfolds in the here-and-now. A spatial perspective highlights people's *in situ* conduct and interaction as these articulate and intersect with the material world shaped by healthcare systems.

The value of considering the *in situ* dimensions of care further emerges from the realisation that what happens in the here-and-now is increasingly complex and unpredictable. We can no longer assume that we know how care unfolds for patients, or that their care will necessarily and neatly map onto a linear trajectory. Patients increasingly present with multiple co-morbidities, medically unexplained symptoms, uncertainty about the need for treatments and referrals, or unrealistic expectations manifesting as requests or demands for unnecessary treatments and referrals.

All these complex dynamics play out between people in spaces and places that accommodate some practices while obstructing others. Given the predominantly technological orientation of contemporary hospitals' spatial design, the authority of those who wield technological resources accrues, while that of those who seek to enact para-technological and interpersonal behaviours and interactions threatens to be devalued and marginalised. In spaces where patients are expected to cope with pain and suffering, but where their treatment pathways harbour inevitable uncertainty and non-linearity, the environment's accentuation of "technocality" can have a significant detrimental effect on patients' experience, and therefore also on their disease progression and their rate and chances of recovery.

Exploring Spatial Dimensions of Care

Taking account of what happens *in situ* is critical for a number of reasons, one of which is the problem of clinicians needing to communicate critical information in noisy, busy and cramped environments. If we consider how clinical teams conduct their handovers, for example, it becomes apparent that healthcare professionals can show themselves willing to risk trading accuracy and precision for habit and expediency. It is only when clinicians become alerted to the risks incurred by communicating sensitive and important information under these unfavourable conditions that they are enabled to redesign their handover processes (Iedema et al., 2009). Generally however, the specifics of *in situ* work do not figure highly on the practice improvement agenda, and special kinds of consciousness raising are needed to enable clinicians to intervene in how they act in specific clinical spaces.

Besides being a critical issue for patients generally, space plays a particularly important role in how we deal with dying patients. When multiple resources are allocated to rescuing and salvaging patients, others whose active care has been declared futile tend to be relegated to lesser spaces with fewer resources. What can be deeply distressing for these patients is the conditions of the environments in which they find themselves: the quality of the paint on the walls, the state of the floors, and of course the amount of noise and busyness that impacts on their space (Collier, 2013). We also hear stories from healthcare workers who feel uncomfortable with inadequate environmental conditions, as these affect the quality of the care provided and the relationships that are enacted. Unfortunately, healthcare workers' aspirations for patients to be in comforting and comfortable spaces are frequently defeated by conditions and regulations that are beyond their control and influence.

Another dimension of clinical work that is strongly affected by spatial arrangement and ward design is infection control. In many open-ward units infection control tends to be enacted on the basis of the *in situ* production of boundaries around the infected patient, reinforced through the use of duct tape, signs, the donning of gloves and of protective equipment. But even in single room wards, determining where the boundary lies between the infected and the non-infected is challenging. Boundaries can shift (due to surfaces becoming infected), objects can travel across these boundaries in unexpected ways (e.g., instruments, gloves, gifts, limbs), people's interpretations of where these boundaries lie or should lie may diverge, and their views on what constitutes adequate infection control measures and behaviours may not be consistent. The spatial dimensions of how clinicians enact infection control are critically important to patients' wellbeing and safety (Wyer, 2013).

In sum, the spatial dimensions of patient care are critical and central, as they influence how the "rubber" of care "hits the road" of patient healing. Yet these dimensions have not been adequately taken into account in healthcare research and policy making to date. This may be because healthcare design is complex enough in relation to the clinical-technical dimensions of care, or perhaps because studying and regulating individuals' movements through space are too difficult to operationalise, and too beset by complexity to convert into useful findings, rules or designs.

Our focus on space teaches us, however, that ensuring patients' wellbeing and safety is and needs to be the responsibility of the individuals moving through the clinical space, and those with the ability to create "on demand" spatial environments and ad hoc boundaries (Thrift, 2004). The complexity of their spatial movements and arrangements notwithstanding, individuals need to negotiate and maintain workable solutions to ensure that their uses of space do not result in exacerbated risk, inconvenience or harm for the patients or for themselves. This requires healthcare professionals to develop what we might term a *spatial literacy* – literacy that enables healthcare workers to be sensitive to and articulate about how they use and produce space. Such spatial literacy includes articulation of the full range of technical and interpersonal implications and consequences for patients of health workers' movements and behaviours in and through their clinical service spaces.

CONCLUSION

Healthcare is enacted across complex systems and spaces. The bureaucratic nature of legislated healthcare systems requires replicable processes and measurable outcomes in order that performance is evaluated and funding accounted for. Yet these systems also need to encompass and be responsive to the diversity, uncertainty and change that is integral to the unique spaces of healthcare practice and the unique people and relationships within them. Healthcare provision should not be understood purely as an outcome of systems design and planning; it must also be understood as an effect of how healthcare workers inhabit clinical space, how their actions mesh with those of their patients and their colleagues in that space, and to what extent these meshings harbour and produce wellbeing and safety for the patients and clinicians who populate that space.

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4. CHANGING DIRECTIONS IN HEALTHCARE

> *"If you do not change direction you end up where you are heading"*
> (Lao Tzu, date unknown)

Change has been an integral part of healthcare throughout history: from the barber-surgeons of medieval Europe to our current-day sterile operating theatres; from polio epidemics to polio eradication strategies; from simple x-rays to sensitive magnetic resonance imaging; from traditional birth attendants to specialised obstetric teams; and from paternalistic models of practice to shared decision making. Change continues to be a feature of healthcare, expanding in its impact and escalating in its pace.

Accompanying this broad impact and fast pace is considerable focus on healthcare changes by research, media and the broader community. Research identifying more efficient ways of providing healthcare is published in relevant journals. Accounts of spiralling healthcare costs and breakthrough drug treatments are familiar newspaper topics. Political debates about healthcare funding often feature on television. Stories of healthcare experiences are commonly shared between friends and family. The public nature of healthcare changes offers opportunities for these changing directions to be critiqued, embraced, negotiated and managed for the benefit of individual patients and the community. However, due to the complex nature of change and the numerous players involved, managing change for maximum benefit is not necessarily easy.

In this chapter we categorise the drivers of change in relation to resource efficiency, information and technology, workforce capability, and human aspects of healthcare. These four important drivers influence the political, organisational, disciplinary, industrial, research and community sectors associated with healthcare. Yet vested interests within these sectors can result in particular drivers being preferenced over others. "So much [that drives health policy in Australia] is ad hoc, short term, and seemingly born out of political compromise, designed to placate vested interests" (Menadue, 2008, p. 170). These different drivers and the resulting tensions have the potential to impact on relationships between health professionals and their patients at the centre of health practice. In this chapter we explore these drivers, consider implications for health practice relationships and highlight the importance of understanding the complexity of healthcare's changing directions.

DRIVERS OF CHANGE IN HEALTHCARE SYSTEMS

Drivers are the factors and forces behind change. Although ideally all drivers would synergistically achieve quality sustainable healthcare, this is not necessarily the case. Drivers are interrelated and can affect each other in different ways. Although we discuss them separately, we caution against inadvertent assumptions that drivers for

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change in healthcare are unrelated discrete entities or that they exert the same degree of influence. Further, they are not static over time nor constant over different contexts.

Drivers Related to Resource Efficiency

The Australian universal healthcare system is facing unsustainable expenses (Martin, 2013). As in other countries, health expenditure in Australia is growing. This growth is largely "driven by increases in the volume of health goods and services purchased, rather than price" (Australian Institute of Health and Welfare, 2013a, p. viii). The growing population, with its increasing proportion of older people with chronic disease, is seeking complex healthcare for longer periods of time. This increasing utilisation of healthcare is accompanied by the need for resource efficiency.

Various strategies are being employed to achieve more efficient use of resources. The Australian government strategy of national health priorities is one such strategy. In the search for cost-effective improvement in the nation's health status, conditions are chosen as health priorities on the basis that they "contribute significantly to the burden of illness and injury in the Australian community" (Australian Institute of Health and Welfare, 2013b, para. 1). In such choices the "burden of disease" is conceptualised in relation to economic implications. The burden of disease for arthritis and osteoporosis, for example, is a cost to the Australian economy of "more than $23.9 billion each year in medical care and indirect costs such as loss of earnings and lost production" (National Health and Medical Research Council, 2014, para. 1). However, with health being a complex entity it is unsurprising that achieving consensus across sectors on the most appropriate health conditions to prioritise is difficult. The Australian Council of Social Services, for example, argues that oral health needs prioritisation because it affects and is affected by economic and social status: "Poor oral health is one of the clearest markers of disadvantage, making people uncomfortable to attend job interviews, apply for housing tenancies or engage in relationships" (Australian Council for Social Services, 2011, p. 2). Prioritising particular conditions over other conditions for national economic advantage can lead to inequity of healthcare access on an individual basis.

In aiming for efficient use of resources, healthcare managers tend to preference instrumental criteria, such as "cost cutting, balancing of budgets, efficient managerial practices, maximisation of profits, and control and disciplining of the workforce according to externally imposed performance criteria" (Komesaroff, Kerridge, Carney, & Brooks, 2013, p. 222). Accompanying this preference for instrumental criteria are healthcare changes using terms such as "continuous quality improvement", "radical reform", "ongoing development", "policy solutions", "transitions", "strategic rethinks", "redesign" and "redirecting resources": terms that are applicable to a range of industries beyond healthcare. The "organisation as a machine" metaphor for understanding organisations has been brought to the fore by recent moves to rationalise healthcare costs through seeking predictable and reproducible services and measurable improvements. This managerial move, as highlighted in the following quotes, has been criticised as insufficient for the complex healthcare needs of patients and for stymying compassion in health.

> A flaw in some of the proposals for fixing healthcare is the failure to address the complexity of patient care in which predictability and ambiguity exist side by side. For example, some hospitals have applied principles of the Toyota Production System to perfect the technique for placing a central venous line. This has allowed them to reduce the associated infection rate to zero – a remarkable achievement – but it has not helped in the management of patients with multiple diseases whose condition is rapidly deteriorating. (Bohmer, 2010, p. 64)

> Increasingly, it seems that the key criterion of the management of a hospital is the balancing of the budget not the achievement of an ethos of caring and ethics. (Komesaroff, Kerridge, Carney, & Brooks, 2013, p. 222)

Evident in these quotes is a sense of conflict between those caring for individual patients and those seeking efficient use of community resources. This conflict can challenge relationships between health professionals and people working in management roles.

Drivers Related to Information and Technology

New information and advances in technology are interrelated drivers of change in healthcare. A vast range of web-based health information is available for health professionals, patients and their families and carers. New technology allows this information to be widely disseminated and quickly accessed. Dissemination of information, telecommunication and management of health resources are part of e-health. Healthcare practice is changing as a result of the new knowledge and new ways of working.

Informed patients are well placed to participate in their healthcare decisions through shared decision making. Yet the wealth of information readily available to patients can be confusing and overwhelming. Many patients need to have technical aspects of health information explained and the quality critiqued. Time and patient-centred relationships are important for contextualising this information to patients' individual situations. Time pressures can impact negatively on the time and relationships required for shared decision-making, as can be seen, for example, in workplaces with staff shortages or quick client throughput. The ready availability of information does not necessarily translate into meaningful information use.

Information is increasingly generated about healthcare practice through the use of technology. This information relates to a range of issues, including patients' length of stay in hospital and validated measures of patient progress. Inpatient rehabilitation staff in NSW, for example, are required to assess all patients using the Functional Independent Measure (FIM) instrument and submit this information to NSW Health for the purposes of benchmarking and costing of services (NSW Health, 2008). It can be argued that the ease of surveillance and the expectations of compliance may compete with health professionals' clinical responsibilities and patient-centredness. In such situations, humanistic decisions for patient care may be tempered with managerial pressure to conform to reportable measures of patients' length of stay.

Management's preference for measurement can also create a divide between managers who see healthcare in terms of numbers and health professionals who have a repertoire of stories to draw on. There is an inherent risk in having two different languages for describing healthcare practice, one based in resource efficiency and the other more concerned with experiential aspects of health. Shared purpose across these different languages can be challenging to negotiate and manage.

In recent times, knowing how to treat illness and diseases is closely linked to the development of biotechnology and pharmaceutical industries. Research breakthroughs in these industries have commercial relevance that can lead to the question, "Who is the primary beneficiary of expanding health information?" For example:

> The behaviour of the pharmaceutical industry – Big Pharma – and the way it exercises power over doctors and governments are deeply concerning. These issues have been exposed, but again what needs to be recognised is that these companies are acting according to the rules of the market place. Their goal is profit maximisation, not health maximisation. (Mooney, 2012, p. 7)

In Australia, structures are in place to ensure the safety of new drugs. For example, to ensure that the benefits to consumers outweigh any risks the Therapeutic Goods Administration applies a range of vigilance tools that include safety studies, adverse reaction reporting, product use tracking, medication incident reporting and information sharing between governments and regulators (Therapeutic Goods Administration, 2012). Yet even for safe products, policymakers and health professionals need to be aware of pharmaceutical companies' impact on decisions.

Drivers in Relation to Workforce Capability

Important for quality healthcare is a good match between workforce capability and the healthcare requirements of the community. An increasingly diverse and specialised workforce is capable of providing care for a wide range of health conditions in a particularised manner. Factors have been identified as contributing to this diversification and specialisation of the healthcare workforce, including "professionalisation, scientific and technological developments, credentialing, changing models of care and identified needs" (National Health Workforce Taskforce, 2009, p. 60). This increasing diversification and specialisation presents both benefits and challenges for healthcare professionals and patients. These benefits and challenges need to be carefully managed and negotiated to ensure workforce capability.

Healthcare provided by a range of different disciplines has the potential to be rich in different skills, knowledge, perspectives and ways of working. These differences may "raise awareness, improve communication, and … change the way services are delivered to and experienced by service users" (Williamson, 2004, p. 161). However, while we recognise the value of various understandings and ways of working, these differences can also challenge open communication and respect between those providing, receiving and managing healthcare. In the absence of shared purpose it can be difficult to practise in a collaborative, patient-centred manner.

Diversification and specialisation also increases the services that need to be “joined up” in healthcare. For example, rehabilitation has moved from earlier reliance on medical treatment, physical therapy and occupational or reconstruction aids to a range of services provided by dieticians, neuropsychologists, nurses, doctors, physiotherapists, occupational therapists, social workers and speech pathologists. These professions, along with others, have expanded, evolved and specialised their roles. Yet these expanding roles and specialisations have not necessarily developed in accordance with holistic or strategic views of rehabilitation. Negotiations between health professionals are commonly required to deal with the resulting overlaps, gaps and differences between perspectives. The boundaries that need to be negotiated by patients and health professionals can be complex.

Teamwork and collaboration, concepts commonly presented as solutions for integrating and coordinating healthcare, receive policy support (e.g. Garling, 2008) and educational interest (e.g. The Interprofessional Curriculum Renewal Consortium, 2013). Interprofessional education developed in response to the traditional silos of health professional education where opportunities to understand other professional roles were sparse. Underpinning interprofessional education are the needs to understand and be responsive to other disciplines’ roles, relationships and views of healthcare and to prepare students for patient-centred collaborative practice. Capability with these behaviours provides a sound basis for positive collaborative relationships between health professionals.

Increasing specialisation also contributes to workforce shortages and maldistribution in rural areas. Specialist and subspecialist positions tend to accumulate in metropolitan areas rather than rural areas. Health professionals in rural areas need more generalist skills. Even in instances where specialist positions are available in rural areas, the training and ongoing professional development tends to be based in metropolitan areas. Professional associations have a large amount of control over entry into subspecialties:

> As the workforce has increasingly fragmented into sub-specialities, each group delineates and protects its own role through such mechanisms as controlling the entry criteria, registration, industrial action and political influence. The greater control each group has, the greater its potential to influence the supply of its own discrete contribution within the health workforce. (National Health Workforce Taskforce, 2009, p. 60)

Health professionals can be uncomfortable with the bureaucratic focus of their professional associations regulating their disciplines and subspecialties. For example, Komesaroff and colleagues (2013, p. 222) contended that:

> the values of cooperative support, the sharing of common experience for the public good, and a commitment to social justice and service are being displaced by highly paid managers committed to corporate values of efficiency, commercial self-interest, and the concentration and maintenance of power. (Komesaroff et al., 2013, p. 222)

The emotion evident in this statement highlights a disquiet between members of a professional association. Health professionals and their professional associations are not necessarily united in their directions of change.

Drivers Related to Human Aspects of Healthcare

The drivers in this category are concerned with people. They include the human rights movement, patient charters, shared decision making, and patient-centred care. Although patients and clients are the main focus, this category also encompasses health professionals involved in healthcare.

The human aspects of healthcare receive widespread attention. From an international perspective, the World Health Organization (WHO) provides leadership for a human rights-based approach to health, as explained in the claim that "the WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being" (WHO, 2013, para. 1). Acting in Australia as the "national human rights watchdog", the Australian Human Rights Commission (n.d.) aims to ensure that all Australians have access to healthcare, in particular those with disabilities or mental ill health and those who are of Aboriginal and Torres Strait Island descent. The patient's right to choose a general practitioner is a well-accepted principle in Australia, with choice restricted only by availability (Healy, Sharman, & Lokuge, 2006). Policy support is also evident. For example, Garling (2008, p. 7) claimed that patients' needs should be the "paramount central concern of the system and not the convenience of the clinicians and administrators". The consumer movement is credited with bringing about "significant changes in attitudes of the health providers, who are now expected to improve patient/customer relations, conduct patient satisfaction surveys, draw up patient 'bill of rights' or charters, and set up informal and formal grievance procedures" (Healy et al., 2006, p. 40). Accompanying this top-down approach to the human rights movement and health service organisation patient charters is interest from health professionals in patient-centred healthcare. However, patient-centred practice can be difficult to enact.

The healthcare sector has been described as representing "a complex web of financing, policy and regulatory interactions between a myriad of participants" (Novak, Berg, & Wilson, p. 10). Health professionals work within this web. Cost containment, financial accountability, time pressures, staff shortages and personal situations are just some of the factors that can influence health professionals' clinical responsibilities and their scope to be patient-centred. Practice of patient-centred care can conflict with the measurable processes and predictable outcomes preferred by resource-efficient management. For example, Dow, Haralambous, Bremner, and Fearn (2006, pp. 1-2) identified enablers of patient-centred care as including factors such as "opportunities for staff to reflect on their own values and beliefs and express their concerns" and "physically and emotionally enriched care environments". These enablers of patient-centred care are not necessarily measurable or predictable. Thus, while patient-centred approaches are encouraged through policy and education, their enactment in healthcare practice can be challenging and can lead to health professionals and patients alike being dissatisfied with healthcare relationships and experiences.

HEALTHCARE CHANGE AS A COMPLEX PHENOMENON

Drivers for healthcare change are not discrete entities that result in predictable circumscribed outcomes. Drivers may compete against each other or work together synergistically. Outcomes of change can be unforseen and have challenging implications. The notion of complex adaptive systems provides a good basis for understanding the complex nature of healthcare changes. As described by Rouse (2012), change is not linear and controlled in complex adaptive systems:

> First, no matter at what level you address a complex system, there is always a broader context that impacts on the system. … Second, complex systems cannot be addressed by a single, traditional discipline. … Interdisciplinary approaches are needed to transform complex systems. Third, the engineering of complex systems requires a professional community that embraces the first two lessons. (Rouse, 2012, paras 13, 14, 15)

The notions of complex adaptive systems and vested interests caution against simplistic expectations for change. As history and current experiences show us, good intentions are rarely sufficient to ensure positive outcomes. While many healthcare changes over time have been beneficial for the health of individuals and communities (such as decreasing death and illness rates by virtue of sterile operating theatres and polio vaccines), this in not always the case.

The medicalisation of infant feeding is an example of a healthcare change with negative outcomes. Following the implementation of a scientific approach to infant feeding early last century, breastfeeding rates decreased dramatically. Health professionals became the "experts" and generations of women's collective wisdom was discredited. Rather than seeking assistance from family members, women turned to healthcare centres for advice and assistance with breastfeeding. However, this "expert" advice to strictly regulate breastfeeding was deemed to be "the main stumbling block to successful breastfeeding" (Kitzinger, 1995, p. 387). Rather than improving infant care by making breastfeeding "scientific" and measurable, the infant feeding changes of last century resulted in poor health outcomes and substantial health costs.

As breastfeeding rates declined, the importance of breastfeeding for maternal and child health became increasingly recognised. Professionals and community groups began supporting and promoting breastfeeding. The huge health cost savings associated with higher rates of breastfeeding rates interested politicians:

> There are strong economic arguments in favour of increasing breastfeeding rates in Australia. … Breastfeeding and breast milk provide well-established health benefits, including greater protection against some chronic diseases, for both mothers and babies. These advantages should also be viewed from an economic perspective, given that fewer cases of illness and hospitalisations at the population level translate into significant cost savings for the health care system. (The Parliament of the Commonwealth of Australia, 2007, para. 3.55)

Measurable goals for breastfeeding rates were set, research undertaken, strategies funded, supportive legislation enacted, and specialist breastfeeding qualifications established. Yet despite this widespread support, declining breastfeeding rates have proved difficult to reverse. Strategies have faltered for a range of reasons, including the presence of a powerful infant food industry, the loss of women's collective wisdom, lack of breastfeeding role models in the community, mothers' work commitments, the sexualisation of breasts, and breastfeeding perceived as belonging "in the home". Adding further to the challenges of the infant feeding situation are mothers who, in their frustration with breastfeeding difficulties, blame breastfeeding advocates for their distress. In this instance, change arising from the drive to use a new approach to infant feeding jeopardised on resource efficiency and the human dimensions of healthcare.

In contrast to this uncontrolled change are carefully planned changes aimed at benefiting patients, health professionals and the economy. The American initiative of transforming primary care practices into "patient-centred medical homes" is a planned strategy that "melds core primary care principles, relationship-centered patient care, reimbursement reform, new information technology, and the chronic care model" (Nutting et al., 2009, p. 254). However, planned change is not necessarily easy to implement. The authors cautioned that it was easy to underestimate the time required for the transformation and the impact on staff roles and relationships: "This type of transformative change, if done too fast, can damage practices and often result in staff burnout, turnover, and financial distress" (p. 256). In cautioning about the need to support staff they highlighted the importance of re-energising staff through education, support and sharing experiences, so that "new energy … became connected to personal change and to a renewed sense of meaning and purpose" (p. 256). The impact of broader contexts on change was recognised in this situation, as was the importance of a multifactorial approach to managing tensions.

CONCLUSION

Change in healthcare is rarely one-dimensional with localised impact. Health professionals and patients need to deal with ongoing structural, management, technological and practice changes. In doing so, health professionals may need to adapt to new healthcare targets, different lines of communication, changing professional knowledge and altered relationships with their patients and other service providers. Negotiating and managing change is a challenge increasingly encountered by those accessing health and those working in the healthcare industry. In undertaking this challenge it is important not to become complacent about the complexity of change, but rather to be attentive to tensions that may play out and to outcomes that might impact negatively on health practice relationships. The impact of change on people and their relationships needs to be recognised.

As health professionals,
we want to be caring,
in caring for others and caring together,
as we embrace new information and new technologies and
engage with emerging professions and ways of working.

And at the same time
we are complying
with cost constraints, policies, performance indicators and discipline boundaries,
with measuring and being measured.

And additionally
we are community members and patients,
So we care about the efficiency and effectiveness of our healthcare systems.

While in this dynamic complex environment of
care and accountability
numbers and people
sometimes
as health professionals we need to care for ourselves,
so we can care for our patients.

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FRANZISKA TREDE AND RICK FLOWERS

5. PATIENT-CENTRED CONTEXT OF HEALTH PRACTICE RELATIONSHIPS

Health practice might be informed by scientific knowledge but it is carried out with people and within social contexts. To this end, much has been written about patient-centred care. The virtues of listening to patients, respecting their health beliefs and behaviours and working with them as partners have been well documented. From the World Health Organization to government agencies to local community health centres, all subscribe and explicitly endorse patient-centred approaches through policies, missions and practice models (WHO, 2000; Kitson, Marshall, Bassett, & Zeitz, 2012). There is no lack of recognition of patient-centred care in strategic plans, professional value statements, codes of conduct and organisational policies. In this literature little attention has been devoted to explicitly integrating this approach with managerial imperatives for efficient patient flow underpinned by allotting a predetermined number of days in hospital for each patient based on diagnosis. Moreover, traditional biomedical beliefs about health, and the dominant imperative for privileging evidence-based practice as best practice, continue to prevail over other ways of knowing and practising healthcare.

In this chapter patient-centred contexts of health practice relationships are framed through historical, paradigmatic and social practice lenses. The interconnected roles of dialogue, critical questioning skills and learning that shape health practice relationships are explored. Technology and digital health are also discussed as emergent factors that radicalise possibilities for reconceptualising patient-centred practice contexts. Conclusions are offered that assert that healthcare practice models underpinned by patient-centred perspectives cannot thrive as an add-on thought or strategy; neither can they thrive on simply appealing to professionals' emotions and relying on their empathy. Conceptualising and realising patient-centred professional relationships requires distinctive practice settings. Such settings foster a respectful listening atmosphere that invites patients to tell their stories, simply starting off by saying what matters to them, including what are their worries, expectations and hopes. Establishing professional relationships by listening to patients places expert practice knowledge discreetly into the background and the desire for dialogical interactions and mutual understanding into the foreground. Within such a patient-centred context, professional interpersonal relationships are placed at the core of healthcare practice and practice knowledge is collaboratively developed, underpinned by values of social justice, wellbeing, rights and responsibility, and respect for diversity.

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THE ROLE OF PATIENTS IN PROFESSIONAL RELATIONSHIPS: AN HISTORICAL OVERVIEW

Until the 1960s, physicians were the authority, responsible for the diagnosis, treatment and healing of patients (Hoving, Visser, Mullen, & van den Borne, 2010). Even if they did supply health education information to their patients, this was frequently not part of a comprehensive healthcare plan. Patients were viewed as passive and were not expected to participate actively in diagnosis and treatment decisions or to ask any questions. In the early 1970s, the first communication courses for healthcare professionals were being developed. Nevertheless, the clinician-centric perspective still prevailed among healthcare professionals and patients were still not active players in the patient education field. In the 1980s, patient education developed parallel to an increasing societal emphasis on patients' rights and the growth of patient advocacy organisations. In the 1990s, patients were considered to be engaged in the promotion of their health and in making choices in treatment and treatment goals. In 21st century communication, patient stories and dialogue have strengthened a growing interest in "shared decision making", where patients are actively involved in decisions with their care providers on the basis of equality (Trede & Higgs, 2008). The influence of important people around the patient, such as partners, children and the broader social network, is recognised and even incorporated in behaviour change interventions such as buddy systems.

From this historical overview we can glean the slow shift from a preoccupation with medical experts curing diseases and telling patients what to do to healthcare teams caring for chronic conditions and collaborating with patients. With the increase of chronic, complex and co-morbid conditions, the need for sustained rehabilitation and working closely with patients has increased. These developments have also changed from an exclusive biomedical perspective of health to a broader and more complex perspective. The WHO (1946, p. 1) defines health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity". This definition, from more than half a century ago, suggests that health is broader than the absence of physical disease and embraces social wellbeing. The definition of health as "being" suggests that it includes mind and body, individual and social, and that it is perceived subjectively. The domains of health are expanding to include social, cultural, economic, environmental and spiritual wellbeing (Marmot, 2005). A patient-centred context for professional relationships therefore needs to engage with the cultural, social, environmental and physical conditions that shape the perceptions of health.

A PARADIGMATIC OVERVIEW OF PROFESSIONAL RELATIONSHIPS

In this section we provide a paradigmatic overview of professional relationships. Paradigms are belief systems that are shared among groups of people. Paradigmatic perspectives address questions of what counts as knowledge and what are the distinguishing attributes of professional relationships. In a patient-centred perspective of professional relationships there are multiple interpretations of lived experiences and there is not one single reality or truth that is external to self. Paradigmatic beliefs about knowledge, health and professional relationships hang together interdependently; one shapes and is shaped by the others. Furthermore, these paradigmatic beliefs are grounded in values, interests and assumptions and influence behaviours. In a patient-centred paradigm, knowledge is a broad concept that embraces experiences and perceptions. A patient-centred context is one where people engage with more than one way of knowing. Knowledge is developed between people inter-subjectively through dialogues and shared understanding which lead to acting together.

To assist in understanding paradigmatic differences that underpin the nature of professional relationships we present in Table 5.1 a simplified overview that distinguishes clinician-centred from patient-centred professional relationships. We acknowledge that there are many more paradigmatic distinctions, such as gender perspectives.

Table 5.1. Paradigmatic overview of clinician- and patient-centred attributes

Attributes	**Clinician-centred**	**Patient-centred**
Philosophical paradigm	Positivism	Realism
Interests and values	Economic, efficient and short term	Humanist, effective and sustainable
Health definition	Reductionist, biophysical, technical	Holistic, sociocultural, practical
Model of health	Illness model, medical world	Wellness model, life world
Role of patient	Passive and obedient	Own expert, interactive, participative, self-determining
Action of patient	Comply	Participate
Role of clinician	Expert sole decision maker, helper to survive	Expert facilitator of shared decision making, helper to cope
Power relations	Clinician claims power, patient is disempowered	Patient and clinician share power
Expectations by clinicians of patients	Not encouraged to think for self	Encouraged to think for self
Nature of patient education	Out of context, objective facts	Within personal and social context, intersubjective values

Attributes shape the purpose, roles and the wider practice context for professional relationships. In this table we make an abstract and crude paradigmatic distinction of the nature of professional relationships without wanting to simplify it. These attributes are rarely actualised in their pure form and may be blurred to some extent in clinical reality. With this table we aim to illustrate that professional relationships are shaped by assumptions and beliefs about health and power. We contend that it is important to deeply understand the beliefs, interests, values and assumptions of clinicians because, purposefully or unknowingly, they set the scene for professional relationships. Clinicians who are aware of the wider practice contexts and the attributes that shape professional relationships are in a better position to make purposeful choices about the role they want or indeed need to play with each individual patient. Furthermore, the attributes not only highlight the skills and capabilities necessary to enact the intended roles but also claim a position and a stance about what kind of role clinicians and patients are willing to take on.

Clinician-centred professional relationships are based on the function of information transmission, or information translation. It can be described as a one-way communication system when health professionals take on the role of the expert who has specific professional knowledge and patients take on the role of the naive, ignorant lay person who lacks expert professional knowledge. This type of professional relationship is characterised by control and monologues based on closed questions that require short yes or no answers.

Patient-centred professional relationships are dialogical relationships underpinned by co-participation and respect for each other's ways of knowing. Such relationships are based on the assumption that scientific and cultural ways of knowing are intertwined in a complex way and that only by collaborating and listening can professionals provide appropriate information and effective services. We agree with Stewart's (2001) definition of patient-centredness which "actually means taking into account the patient's desire for information and for sharing decision making and responding appropriately". This notion of patient-centredness implies that rather than telling patients, clinicians should listen to patients with the aim of identifying what it is they still need to know.

Tensions between scientific and cultural ways of knowing persist and continue to be the focus for many philosophers, researchers and practitioners alike. We note here that professional relationships are not only shaped by individuals but are also the product of both individual and social agency.

Paradigmatic perspectives often remain unnoticed because they are invisible and implicit. However, they can be exposed by the way people think about health. The question of who and what is responsible for improving wellbeing has a profound effect on what patients and clinicians expect from each other. Expectations set the scene for how patients and clinicians relate to each other and what role they are willing to play. People who believe that their body is a machine that simply needs fixing by an expert mechanic assume that there is no need for them to participate in their healthcare plan. They assign themselves a passive-submissive patient role. On the other hand, patients who believe that their physical health is closely related to their social, cultural and educational capital assign themselves a more proactive, responsibility-sharing role. Patients who believe in their own responsibility for health will display agency and seek dialogues with clinicians.

Framing Health Practice Relationships Through a Sociocultural Practice Lens

Another way of exploring health practice relationships is through a social practice lens. Like other discipline-specific professional practices, health practice is foremost a social practice conducted by people fulfilling distinct roles in designated professional relationships (Schatzki, 2002). Practice in this sense comprises so much more than profession-specific knowledge and technical skills; it also includes dispositions, moral values and actions, decision making, professional judgement, relating to others, communicating with diverse groups and, last but not least, learning. All these practice features are interconnected and interdependent. Practice is situated because it occurs in a specific time and place and becomes alive in unique sociocultural practice contexts. Most of what is practised is routine and predictable, but there are aspects of practice that can never be fully predictable and where learning to respond in the moment is required (Zukas & Kilminster, 2012). Practising patient-centredness can be such a learning moment.

Exploring health practice relationships through a social practice lens brings the relational and dialogical aspects of health practice into focus. Attention is not on professional knowledge and expertise but on the doings, sayings and relatings (Kemmis & Grootenboer, 2008). The way patients and clinicians work and talk together and relate to each other shapes their interpersonal professional relationships. The focus is on interpersonal spaces that are immediately intersubjective and mutually construct practices. Observed through a relational and discursive lens, notions of detached objectivity and rational professionalism are contested as one-dimensional and incomplete notions of professional practice and practice relationships.

Practice relationships are nested within the workplace context and culture in each professional health setting, shaping the roles patients and clinicians assume. The workplace context and culture include physical layout, rosters and work shifts, technical instruments, and what counts as important and legitimate activity. The nature of social atmosphere and workplace culture, or what is valued and what is not, often remains invisible and implicit. The way people interact with each other and objects in space and time further shapes the context for professional relationships. Workplace cultures abound with symbols and routines (rituals). Clinicians who are oblivious to workplace culture and work atmospheres more often are shaped by them rather than shaping them. The interconnections between the physical and cultural dimensions of a workplace and how they influence health practice relationships remains under-researched (Trede, McEwen, & Sheehan, 2013). The spaces in a workplace are part of the contexts that shape professional relationships and, as Lyon (2004) suggests, workplace contexts are intersubjective and therefore can be transformed. In what follows we explore the role of dialogues in shaping interpersonal relations.

FRAMING HEALTH PRACTICE PROFESSIONAL RELATIONSHIPS THROUGH DIALOGUES AND STORIES

Dialogues enable engagement; however, they are fragile undertakings that can easily be hijacked by one dialogue partner. To simply conduct a conversation and appreciate how the "other" makes sense of situations is insufficient. Dialogue and meaning-making require close scrutiny by looking beneath the surface. What has been said needs to be followed by deeper questions such as "How important is this?", "Why did she say this?", "What are the ulterior motives and intentions?", "Is the dialogue privileged by a biomedical or sociocultural understanding of health?". Based on Habermas' theorising (1984) on what constitutes good communication there are three conditions we have extrapolated for patient-centred dialogues. These conditions are that both dialogue partners (1) disclose their bias and refrain from rhetoric and unsubstantiated claims that can mislead the other; (2) take a self-reflective stance; (3) articulate their reasoning rather than exerting power over the other. In other words, a patient-centred approach to dialogue is underpinned by a curiosity to establish what is needed from multiple perspectives. It requires insightfulness, perception and acknowledgement of both parties. Both emotions and logic play into patient-centredness. The ability to draw out what really matters to patients enables clinicians to work with patients in a patient-centred professional relationship.

Without shared expectations, participation and interactive dialogues, it is very likely that patients and clinicians live in two parallel worlds that do not intersect. A recent study of patients' perceptions of patient-centred care confirmed that key issues for patients had not been adequately addressed by hospital staff. Patient issues included respect, mutual trust, and clear and open communication (Ferguson, Ward, Card, Sheppard, & McMurtry, 2013). Respect meant that clinicians knew their patients as people beyond symptoms. Mutual trust meant that patients felt clinicians showed authentic empathy and interest which encouraged patients to get involved in their care process and participate in decision making. Open and clear communication was not only about access to information but an expectation by patients to engage in discussion about the information. Telling knowledge was not sufficient. Patients wanted to interpret information with their clinicians. Ferguson et al. found that almost half of their patient participants were not satisfied with their care experiences. They concluded that exposure to patient-centred experiences was needed. However, we question whether exposure without epistemological grounding is sufficient. Clinicians who conceive of themselves as biomedical experts who know best how to deliver efficient care can easily dismiss patient-centred approaches as fickle, time-wasting and emotionally draining.

Health agencies recognise that quality improvement in health services is connected to "good" patient experiences and effective dialogues. The various ways patient experiences are evaluated include patient satisfaction surveys and the collection of patient stories. Patient stories are part of the wider patient-centred movement and an increasingly popular approach to establishing meaningful patient-centred professional relationships (Charon, 2006). Patient stories are immediately subjective, encourage active involvement, reveal the beliefs of the storyteller, provide distinct interpretations of situations, and create a space for discussing feelings and subjectivities; stories are an invitation to share experiences (Riessman, 2008). Stories can interrupt clinicians in their routine of getting things done (Frank, 2012). They can be a reminder of what is really important and what is really needed rather than diligently following task patterns. Patient stories can only be effective if they are responded to, which means that clinicians need to be willing to be interrupted in their routine. Charon (2006, p. 191) emphasised the importance of listening, claiming that the tasks of clinicians "include the duty to bear witness as others tell of trauma and loss". Through listening, patients talk and can convey their stories to professionals, which in turn is a reflective act that helps patients to make further sense of what matters to them. Charon (2012, p. 1880) succinctly described the reciprocal nature of patient-centredness in the following: "The contact between doctor and patient provides the ground for reciprocal recognition. Each comes to know things about the other that help the other, while being granted a view of self". Patients learn about clinicians and clinicians learn about patients and, at the same time, learn about themselves. This implies a reflexivity which goes beyond one-way listening and responding. Clinicians are learners and patients are teachers. This reciprocity and interdependence of listening, speaking and learning democratise and humanise professional relationships. Patient and clinician can meet at a human level. Storytelling, from this perspective, does not necessarily lead to more efficient care and does not work to economic or biomedical imperatives. What this approach enables is a cultural and truly people-centred way of being together which at the same time can transform health practice contexts. A patient-centred context is created through changing one's self (Aujoulat, d'Hoore, & Deccache, 2007). It requires thinking about the other and thinking about self in relation to the other.

Attention to detail and to personal circumstances are key features of patient-centredness. This attention is further underscored by compassion, empathy and an ability to consider "the other". These aspects all speak to humanity, diversity and complexity rather than to the application of universal rules and routine practices. Patient-centredness is based not on rhetoric, cognition and logical thought but on ethics, cultural awareness and interpersonal dialogue. To some extent patient-centredness is based on an optimistic outlook and a belief in human goodness. Patient-centredness cannot be captured from only one perspective or one party. Patient-centredness is built on dialogue, collective reflection on what is at stake and an awareness of the possible consequences of acting together that might be seen as a risk from a purely scientific perspective. Practices based on empirico-analytically derived evidence might not be the best practice in all situations. It is impossible and not sustainable to mandate compassion and moral deliberation, but it is possible to articulate the value of cultural contexts of professional relationships. Stories are a suitable vehicle for patient-centredness because they expose clinicians to cultural ways of knowing about health. Stories are engaging and immediately privilege subjective, cultural and individual points of view. Stories reveal what is important to the storytellers, how they live with a health condition and its impact on their lives. Providing patients with opportunities to tell their story renders them some control, which can have enabling effects on them to take stronger responsibility for their recovery. The context in which questions are asked and the nature of dialogue that follows are essential in shaping health practice relationships and making judgements about their patient-centredness.

COMMUNICATION, KNOWLEDGE AND THE INTERNET

The rapid developments of information technology have also begun to infiltrate healthcare delivery and how patients and clinicians communicate with each other. With the advent of the digital age, possibilities for participation, information exchange and support groups in the healthcare sector have expanded dramatically. In addition to health literacy, patients need to become increasingly more digitally literate. Through access to the Internet patients can inform themselves about diagnoses, symptoms, prognoses and the like. Blogs, wikis, and other social media (web 2) enable patients and carers to seek advice not only from professional experts but also from peers. Digital support groups are flourishing. The Internet has brought to our attention the changing role of clinicians in communicating and educating patients. Patients no longer need to depend only on their local clinician because they can also connect with people, whether lay or professional, around the globe. Danowski Smith (2013) labelled these patients “patient 2.0”.

Today, health practice relationships can be seen in a three-way communication loop between patient, clinician and the world. This shift towards a globally connected patient community offers new possibilities for peer support, peer mentoring and giving voice to patients. It also provides challenges for clinicians in terms of how to engage with these digitally literate and connected health consumers. Knowledge no longer resides exclusively with health professionals, but interpreting and differentiating aspects of knowledge to social situations and individual experiences of patients becomes an important capability. In the digital age, clinicians more acutely than ever need to rethink their roles because they are no longer in exclusive possession of expert knowledge. Through digital access to information, clinicians are more needed as facilitators and moderators of health information and as coaches who help patients make sense of this information for their own needs and situations.

CONCLUSION

With this chapter we aimed to provide better understanding of the context for patient-centred professional relationships and a stronger stance to argue for it. We commenced by exploring the patient-centred context for health practice relationships. We provided a historical overview of the developments of health practice relationships from clinician-centred to patient-centred relationships. We discussed how health practice relationships can be understood through two broad paradigmatic lenses. Paradigmatic perspectives explain that professional relationships are products of world views where beliefs about what constitutes knowledge and health are of prime influence. A social practice lens is a useful reminder that health practice is not conducted in isolation but is predominantly a social practice that involves people working together. As a social practice and with a focus on patients, health practice relationships need to be based on ethical, moral, compassionate and social justice values that embrace the life world and cultural ways of knowing. The expectations of all involved need to be articulated and attended to. Furthermore, a patient-centred context that invites engagement and active participation is crucial. Professional relationships that are privileged by instrumental, economic and efficiency stances would allocate patient-centredness a minor role at best, or undermine it as unprofessional and irrational at worst. Understanding the reasoning behind patient-centred relationships through social practice theory and communicative action theory provides clinicians with a deeper understanding of the nature of patient-centredness.

We propose to frame professional relationships within a perspective of reflective and self-critical communication and shared understanding by learning from each other to gain insights and new knowledge. We suggest using stories to evoke what it means to be human and to stimulate reflections on current notions of professional relationships. To be human means to think for self, make sense of experiences and, based on these deliberations, to act purposefully. Furthermore, to be human means to be able to question self, explore feelings and assumptions that shape the way people reason, and consider consequences of decisions and actions. Our perspective of patient-centredness goes beyond emotion and compassion. We argue that patient-centred contexts should be motivated by a sense of social justice. Patient-centredness cannot be an add-on to models that do not value cultural and social perspectives. Patient-centred contexts can only be created together with patients through reciprocal relationships where patients and clinicians listen to and learn from each other.

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SECTION 2: UNDERSTANDING PROFESSIONAL RELATIONSHIPS

DIANE TASKER AND JOY HIGGS

6. PROFESSIONALISM AND RELATIONSHIPS

Balancing Interests

Professionalism?

White coats
Distance
Unbiased
Impersonal
Self-protection
Is this me?

Compliant
Distanced
Disempowered
Just a number
Seeking a human touch
Wanting them to see me

A new era
Re-thinking patient-centred care
Not delivery to and for
Me and you
But collaboration
Between us

Professionalism needs to change

In a world of increasing population and complexity, modern healthcare needs to place the care of individuals at the centre of healthcare interactions if people's rights are to be supported and protected. This is particularly important for clients with conditions which might particularly disempower them in interpersonal interactions, such as impaired communication, physical impairments, life crises, and mental health concerns. Such challenges are compounded when clients face other life concerns such as lack of familiarity with the dominant culture or language, educational or socio-economic barriers to participation and social dislocation (e.g. refugee status, homelessness).

Increasing society expectations about healthcare access, quality and information availability challenge professional relationships that were historically distant and

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"clinical" in nature. In this complex healthcare arena a new interpretation of professionalism and human relationships is needed to address these challenges. This chapter explores ways that professionalism is enacted through the medium of human relationships and presents an example of a particular tension in professional practice: how professional friendship might be appropriately realised. Consideration of such situations can assist us to better understand possible "boundaries in relational care" that might be considered and adopted by practitioners in their pursuit of blended professional *and* relationally-mindful practice.

RELATIONSHIPS IN HEALTHCARE

It has often been argued that good health requires people to be in relationship with other people, their community and their environment and that those human relationships occur reciprocally. Carefully tailored engagement with clients about their care has been shown to improve health outcomes (Greene & Hibbard, 2012). More generally, client involvement in healthcare which puts clients "at the heart of the healthcare process" is poorly understood by both practitioners and clients, with few definite ideas or activities to uphold the concept of that involvement in practice (European Union, 2012, p. 6).

> Health is not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one's fellow human beings, of active and rewarding engagement with one's everyday tasks. (Gadamer, 1996, pp. 113-114)

This realisation is one that is often neglected or even rejected in the world of evidence-based and commodified healthcare, that is, healthcare that is seen to be necessarily grounded in scientific evidence and purchased and delivered as a sales item. As a consequence, health professionals are typically socialised into an expectation of being "professional", often translated as requiring them to maintain a professional distance from their patients and clients. The positive aspects of such a tradition are that clients should be protected from unprofessional and unethical behaviours such as coercion, abuse of power and improper relationships. However, professional distance can be perceived by clients as "clinical", uncaring, distant, authoritative and disempowering. The importance of human interaction in health, as argued by Gadamer above, is lost in this interpretation of professionalism.

This argument is reinforced by the World Health Organization (WHO, 1978, 1986, 2005), which has recognised and endorsed that increased consumerism and greater availability of health-related information for the general public has contributed towards an increased demand by clients and their families for fuller involvement in their healthcare and such expectations. The WHO policy advice includes the empowerment and inclusion of people in and for their own health and wellbeing. Positive and productive relationships are needed between clients and healthcare practitioners if such challenges are to be met.

Practitioners need to consider these increased demands for involvement by clients within the framework of their professional approach to healthcare, often when time is at a premium and it is not always clear what that involvement might mean. Healthcare practitioners need to relate to clients in ways that will further their health and wellbeing, but also need to feel satisfied with their interactive work with clients and able to sustain their practice.

PROFESSIONALISM AS AN ETHICAL FRAME FOR HEALTHCARE RELATIONSHIPS

Professionalism within healthcare is necessarily and fundamentally enacted via the interpersonal relationships that develop between the people involved. Clients and their families and carers depend on the professional attitudes and behaviour of their healthcare practitioners within therapeutic relationships which can be defined as "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect" (Coles & McLean, 2003, p. 33). Speaking about private and difficult healthcare issues (mental, emotional or physical), needing care, and letting another person look at and touch your body often in intimate and sometimes painful ways or knowing about private and sensitive personal information and feelings requires a special interpersonal relationship that enables trust and honesty to develop.

Such experiences are not easily expressed in techno-rational language and do not fit well within dominant healthcare discourses where objectivity rules. Historically, the scientific method that has provided so much of medicine today inherently involved a Cartesian duality of thought and practice in healthcare which effectively attempted to separate people from their bodies, with the laudable intention of improving the function of those bodies to induce or achieve good health. Indeed some aspects of medicine today, such as surgery and emergency medicine, still depend on a certain separation of body and mind. The nature of such techno-rational discourse also fits well with managerial goals and values. However, as argued above, the quality of healthcare provision will be enhanced by paying attention to the experiences of healthcare by its recipients (or, preferably, collaborators) and practitioners. Very different language will be used in the relating of stories to help build understanding between practitioners and clients within such person-centred professional relationships.

Healthcare relationships are essentially human in nature while still framed by this changing picture and embodiment of professionalism. In the difficult space between healthcare planning and provision and the experience of healthcare as related by clients, families and carers, the effect of professionalism on and within healthcare relationships can be viewed as attitudinal in nature, setting the scene for healthcare activities and interactions and providing support for an ethical basis to promote client care above the interests of the practitioner. Yet such attitudes are part of a larger frame of reference that encompasses the practitioner's practice philosophy and practice model. We argue that such models should be knowingly formed and responsibly owned, rather than inherited through professional socialisation and blindly followed.

The promotion of the client's interest is particularly important because healthcare professionals are financially remunerated for their healthcare work with clients. Practitioners need and are required to act in an ethical way, always putting the wellbeing of the client to the fore in their work with them. Practitioners provide special services (as a function of their professional type) but clients also enter that contract with their body if not their will, aspirations and active collaboration.

Relationships between practitioners and clients involve a "contract of care", which includes both a commercial aspect and a human relationship aspect. In an effort to consider more deeply and understand this human relationship between clients and practitioners in healthcare, models of person-centred and relationship-centred healthcare have expanded the way that healthcare interactions can be viewed by encouraging and engendering relational environments in practice. Person- and relation-centred approaches to practice can strongly ground professional healthcare and contribute towards the compassionate development of healthcare relationships by maintaining the emphasis of care on the whole person, paying attention to the subjective experience of the client and promoting continuity in clients' lives and sense of self. Both models acknowledge the need for all parties in healthcare to communicate with each other freely as people as well as healthcare practitioners and clients/patients. "At the core the patient-centered care is the quality of interactions between patients and care providers" (Jayadevappa & Chhatre, 2011, p. 22).

THE CARING PROFESSIONAL

Healthcare practitioners learn to balance qualities of care in their professional practice with clients and families. Although ethical healthcare intrinsically involves caring aspects of health practice relationships, this aspect of healthcare is placed within the context of complex decision-making, demanding procedural rigour and often overwhelming time, workforce and cost constraints. Despite ethical, regulatory and institution-driven guidelines set down for professional health practice, being clear about the nature of professional relationships in healthcare and the necessary choices embedded in them is not easy.

In the course of any healthcare career, many relational situations occur that require careful reflection and consideration by practitioners. For example, it is often inevitable that ongoing interactions between practitioner and client develop more personal aspects such as friendship, respect, concern, support and advocacy, as well as "personality conflict", anger, fear, disrespect and mistrust. With the advent of increasing incidence of chronic and complex situations to be addressed in healthcare, practitioners may need to interact with clients over long periods of time or live alongside them in small or rural communities. Professional bodies provide codes of ethics to guide professionals in this delicate area of practice, but the ephemeral and individual nature of interpersonal relationships can still cause dilemmas in practice for both parties in a healthcare relationship. Such tensions, maybe unspoken, are often quietly reflected upon by healthcare practitioners, uncertain of how and when to proceed relationally with their clients.

Bringing "self" into one's professional practice is an essential part of the way health practitioners interact with clients and families (Higgs & Titchen, 2001) but the management of such integration requires mindfulness, critical self-reflection and willingness to change behaviours and expectations. Reflection can prompt powerful learning for practitioners, with both personal and professional implications for practice. For example, the issue of acceptable degrees of friendship can be an ever-present tension within healthcare practice as health practitioners strive to balance being "friendly and welcoming" in their professional manner as a caring professional with what Grayling (2013) referred to as being a "real friend", someone "whom one admits to psychological places that the others cannot go" (p. 186), or exceeding acceptable relationship boundaries and abusing the client's trust.

In the following poem, occupational therapist and academic Kinsella reflects on the tension of developing friendship in a professional relationship with a client. The use of poetics to access such a difficult area of professional relationship development seems to have allowed this professional to reflect upon and more clearly identify necessary "boundaries in relational care" that could protect her client from any added burden or distress above the exigencies of a difficult healthcare situation.

Professionalism

I was too professional
Louise
To give you the gift
A carefully picked out
remembrance

Of the hours we'd spent
planning your death
Negotiating the
painful intimacies
of the end of your life
Every other day
for a year

You—reminding me of me
Friendship blooming
where it should not

How unprofessional
to allow you to creep into
my heart!

You—my patient
not my friend

Your body's disappointments I know
of necessity
It is my job

I transgress by visiting
your family in the evening
on occasion
in emergencies
Your last Christmas
I keep the gift in my bottom drawer
guilty

You in your wheelchair
embarrassed to be seen by those
who knew you when you were beautiful
venture out with dark glasses, a scarf on your head, to buy
a treasure for me!

My professionalism
weighs heavily in my chest
as I ask your ghost for forgiveness
(Kinsella, 2006, p. 41)

The boundaries between self and professionalism in a healthcare relationship can be indistinct, but reflection such as that expressed in this poem raises not just the issue of friendship within a professional healthcare relationship but also the inherent nature of professional relationships, which may initially be based on a contract for health service but are always human with the shades of emotion and care that must occur in a human experience.

> In human-related professions there is a gradual recognition of the flow of experience between various roles that people take on in their daily lives. To some extent, people's inner and outer experiences are seen as connected rather than compartmentalised, and the multiple and enfolded nature of what people do is starting to be acknowledged. (Denshire, 2000, pp. 3-4)

CONCLUSION

Healthcare practitioners face great challenges practising in a caring and professional manner that will promote clients' interests but also safeguard the sustainability of practitioner identity, practice, job viability and career. Balance between these issues is necessary because the ethical concern for the interests of clients (a basic requirement of professionalism) is set against the general commercial basis of healthcare interaction and the position of clients within healthcare relationships, which is often disempowered compared to that of practitioners.

The identification and raising of personal awareness of tensions in relational professional practice has been considered through the particular example of a developing friendship within one practitioner/client relationship. Mindfulness was enhanced by personal narrative reflection, in the form of a poem, melding professionalism and relationships to protect the interests of the client within a challenging healthcare relationship and sustaining the ongoing practice and development of the practitioner concerned.

In this chapter we have emphasised the importance of human relationships in healthcare and have proposed that the concept and practice of professionalism need to continue to evolve to provide a viable ethical framework for healthcare relationships which change over time, people and situations, in order to allow and encourage productive relationships and practice with clients, families and carers.

Open minds
To changing situations and changing expectations

Review our professionalism
Within evolving standards and changing relationships

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7. NEGOTIATING HEALTHCARE RELATIONSHIPS THROUGH COMMUNICATION

Healthcare relationships are complex and multidimensional. Managing and negotiating such complexity and diversity presents challenges for all concerned. Meanwhile, positive health outcomes are contingent on the successful management of diverse healthcare relationships. In this chapter we draw on a social-ecological model of health promotion to scaffold the complexity of relationships within the healthcare context and then focus on communication as a critical way to link dimensions of those healthcare relationships at system and individual levels.

HEALTHCARE RELATIONSHIPS: A SOCIAL-ECOLOGICAL MODEL

A number of models might be used to characterise the complexity and diversity of healthcare relationships (VanLeeuwen, Waltner-Toews, Abernathy, & Smit, 1999). In this chapter we take one such model as a framework for our discussion of healthcare relationships. The social-ecological model (Figure 7.1) draws from work in human development by Bronfenbrenner (2005) but has been widely applied to a variety of fields of scholarship. In seminal work, McLeroy, Bibeau, Steckler, and Glanz (1988) used the social-ecological model to provide a new framework for health promotion, allowing the two key notions of *behaviour* and *environment* to provide a context for discourse around health promotion. We argue that this model provides a useful framework for understanding healthcare relationships, demonstrating the complexity of relationships that are always mediated through individuals (at the centre of the model) but that sometimes have wide-ranging implications.

Nested Dimensions of Healthcare Relationships

According to the social-ecological model, healthcare relationships operate within a series of nested dimensions (see Figure 7.1) representing how healthcare relationships exist over a wide range of dimensions from the micro (individual) to the macro (national and international health policies and initiatives). These dimensions are:

- Individual (intrapersonal) dimension – relationships with others are built upon characteristics of the individual such as belief-systems, attitudes, gender, ethnicity, education, behaviour, self-concept, socioeconomic status, cultural background, life history and experience

J. Higgs et al. (Eds.), Health Practice Relationships, 57–64.

- Interpersonal dimension – relationships between individuals; their formal and informal networks include clients, healthcare providers, family, work groups, friends and hospital staff
- Organisational dimension – this includes the hospital or particular service provider practice and professional associations that govern professional standards
- Community dimension – this includes area health networks, community-based healthcare services, community services, relationships in and between organisations and informal networks
- Public policy dimension – this includes issues of local, state and federal laws and policies as well as the two competing health paradigms of public and private care.

The social-ecological model is useful for framing healthcare relationships because it conceptualises the multiple dimensions in which these relationships operate. Relationships can exist in and between all the above dimensions, but they are usually mediated through the interpersonal relationships of the individuals that represent them. For example, a Minister for Health or a departmental spokesperson may become the face of the relationship between policy and an individual provider.

Although it is difficult for a model of healthcare relationships to capture the extent of the complexity inherent in these relationships, we believe that appreciating the dimensions of such complexity is critical to understanding the quality of healthcare relationships and their impact on client outcomes. The social-ecological model helps conceptualise the complex nature of healthcare relationships that operate simultaneously at a variety of system and individual dimensions. The negotiations and encounters that take place are contingent on the relationships between individuals involved, including clients, carers, healthcare workers, advocates, managers, politicians and policy makers, at every interaction.

COMMUNICATION WITHIN HEALTHCARE RELATIONSHIPS

Healthcare relationships between the people involved are principally negotiated through communication. Communication is the mechanism for movement of information, decision making, intervention, health behaviour, knowledge, care, and all other relational transactions to occur within the network. According to Schiavo (2007), the key characteristics of good communication within healthcare relationships are:

- Audience-centred
- Research-based
- Multidisciplinary
- Strategic
- Process-oriented
- Cost-effective

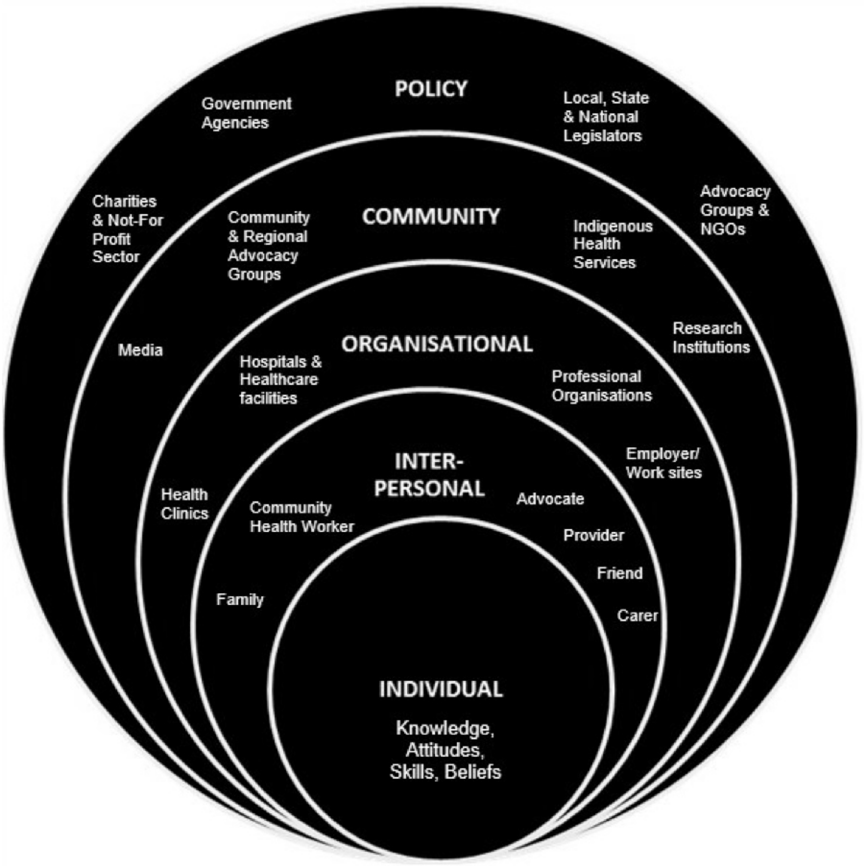

Figure 7.1. A social-ecological model of healthcare relationships. After Dymek et al. (2013), p. 14

- Creative in support of strategy
- Audience and media specific
- Relationship building
- Aimed at behavioural or social change.

However, relationships between individuals are difficult to represent in the social-ecological model because the model captures the *dimensions* of relationships rather than communication of information and ideas *between* individuals. Healthcare relationships might be best considered as a series of nested dimensions enmeshed in a complex web of communication. The effectiveness of communication between the individuals involved has a strong influence on the quality of healthcare relationships.

HEALTHCARE RELATIONSHIPS: COMMUNICATION BETWEEN INDIVIDUALS

The dimensions of healthcare relationships at the individual client and health professional level are complex and dynamic. Client-centred healthcare requires health professionals to respect, value and engage with their clients as individuals and as decision-makers in their own healthcare. Health professionals also need to respect and value each other as individuals and skilled health professionals with an identified role in the team (Croker, 2011).

Studies indicate that influences on healthcare relationships include the socioeconomic status, age, gender, ethnicity and social networks of both clients and health professionals (Ackerson & Viswanath, 2009). Although the dimensions of healthcare relationships at the individual level are diverse, communication has been identified as key to the quality of healthcare relationships between health professionals and their clients as well as between different health professionals (Higgs, McAllister, & Sefton, 2012; O'Toole, 2012).

Communication for Collaborative Client-Centred Healthcare

Effective communication is crucial to developing the relationships between healthcare professionals and their clients that underpin collaborative client-centred healthcare. Communication not only involves exchanging information; it is also "concerned with the negotiation of relationships and all the complexities inherent in those relationships, such as identity, power and culture" (Ajjawi & Rees, 2012, p. 15). Higgs et al. (2012, p. 7) further stated that "communication should, first and foremost, be conducted in the spirit of humanity".

Supportive client-centred communication demonstrates empathy and involves active listening skills, using verbal and body language and tone of voice to convey interest, concern and attention relevant to the individual client (Higgs et al., 2012). Demonstrating respect and compassion, providing clear explanations (Trede & Haynes, 2008) and confirming that the client understands information provided (Ajjawi & Rees, 2012) are also essential components of sound communication in client-health professional relationships.

The manner in which the health professional presents, organises and sequences this information and its relevance and timeliness to the individual client are important for positive health outcomes (O'Toole, 2012). Health professionals need to be mindful of the different assumptions, expectations, rules and meanings each client brings to the interaction and how these may influence communication processes and outcomes (Ajjawi & Rees, 2012). The physical environments in which interactions occur also require careful consideration. These include aspects such as noise levels, lighting, the presence/absence of other people, and maintenance of the confidential nature of the information exchanged.

Healthcare relationships and communication are strongly influenced by the social and cultural context of a healthcare situation (Ackerson & Viswanath, 2009). Effective communication requires health professionals to be culturally competent and consequently knowledgeable and skilled in communicating with clients who are culturally and linguistically diverse (Higgs et al., 2012; O'Toole, 2012). Skills to work effectively with interpreters are essential. Communication is verbal, nonverbal and written, formal and informal. The formality of the language, the jargon and gestures used, and the strategies for negotiation and conflict resolution need to be tailored to the individual client (Ajjawi & Rees, 2012; Higgs et al., 2012). Health professionals must be aware of the many variations in meaning of nonverbal cues across individuals and cultures, and of their personal manner in using the elements of nonverbal communication (O'Toole, 2012). The paralinguistic aspects of communication, notably speed, tone, volume, pitch and intonation, must also be considered to ensure effective communication (Ajjawi & Rees, 2012).

Adapting all forms of communication to individual clients, including to their age, gender, educational and cultural background, health and psychosocial status, will promote the effectiveness of this communication and the therapeutic relationship. Avoiding stereotyping of clients is crucial (Ajjawi & Rees, 2012). Equality in power, common understandings and shared relationships and mutual willingness to understand each other's perspectives all have a positive impact on health outcomes (Ackerson & Viswanath, 2009; Duggan, 2006). O'Toole (2012, p. 163) states that "non-judgemental communication is key to overcoming the inherent power imbalance in the relationship between … health professional[s]" and their clients.

Professional and workplace standards, including ethical behaviours, are implicit when communicating with clients and family members. Inadequate communication between clients and health professionals is a major source of complaints to ethics boards (Body & McAllister, 2009). Ineffective communication between health professionals also constitutes a risk to client care and can result in adverse client outcomes (Australian Commission on Safety and Quality in Health Care, 2011).

The complex nature of communication between health professionals and clients and the uniqueness of each client-health professional relationship requires health professionals to engage in regular self-reflection and self-evaluation. They need to critically evaluate their own professional performance, their knowledge and skills, and to take a lifelong-learning approach to their careers (Higgs et al., 2012). Health professionals require an evidence-based practice approach that includes not only research and clinical findings relevant to individual clients' health issues and their broader knowledge of individual clients, but also evidence relevant to effective communication and therapeutic relationships. Health professionals need to integrate this information from different sources and make decisions in a collaborative manner with their clients.

High-level communication, reflection and clinical reasoning skills are required to enable health professionals to adapt their communication to individual clients, clients' changing needs and situations, as well as the healthcare context. Before each interaction with a client, the health professional needs to consider the various factors likely to impact on the interaction and determine how to optimally manage the situation. Self-reflection and self-evaluation follow each interaction. According to Ajjawi and Rees (2012, p. 22), the key to effective communication is for health professionals “to be open, flexible and reflective” about both their communication skills and their relationships with others. When clients have complex health problems and several health professionals are involved in their healthcare the complexity of the communication and relationships is magnified.

Communication Within Interprofessional Healthcare Relationships

Skilled communication is essential to forming and maintaining the interpersonal relationships that are integral to collaboration between health professionals (Hutchings, Hall, & Loveday, 2003). Higgs et al. (2012, p. 5) argue that “good communication among health professionals is the basis of the effective teamwork necessary for the efficient delivery of healthcare services”. Adequate time and proximity, preferably co-location, are important for the development of these productive collaborative relationships (Epstein, 2005). Epstein further maintained that issues related to power differentials need to be addressed to promote collaboration with the aim of equalising power between health professionals.

Clear lines of communication are crucial for the development of positive relationships. Communication systems may be formal, such as in organised health professional team meetings that use professional language. Communication may also be informal and spontaneous and use more colloquial language (Portsmouth, Coyle, & Trede 2012). Moreover, health professionals require sound written communication skills to meet the legal requirements of their professional documentation (Higgs et al., 2012).

The dynamic nature of teams, their complexity, changing team membership, stability, decision-making processes, and their size and proximity all contribute to the need for varied and clear communication systems (Croker, 2011). Trede and Smith (2012, p. 294) argued that assertiveness is an important skill for health professionals because it “fosters effective communication skills, enhances effective teamwork and conflict resolution, and supports client advocacy”.

Further challenges to effective collaborative teamwork arise from the diversity of health professionals involved with the healthcare of individual clients. Health professionals not only have different personal and professional experiences but also different discipline-based understandings of health, healthcare and teamwork (Croker, 2011). Croker’s research (2011, p. 222) found that effective collaborative teamwork occurred when health professionals engaged positively with each other’s diversity, demonstrating an “openness to each other’s perspectives and skills” and a willingness to adjust to each other’s ways of working, negotiated unique and shared team-member roles, and established formal and informal communication systems.

The communication skills required by health professionals when working together collaboratively to optimise client-health outcomes are similar to those required for effective communication with clients. These include the ability to negotiate meanings, reach shared understandings, engage in active listening, questioning, and providing, responding to and clarifying information (Croker & Coyle, 2012). Trust and respect are universally valued in combination with a willingness to work with others (Croker, 2011). Further, health professionals must communicate with each other in a culturally competent manner (O'Toole, 2012).

IMPLICATIONS OF RELATIONSHIP DIMENSIONS FOR HEALTHCARE PRACTICE

Collaborative client-centred practice requires timely, effective and efficient communication between health professionals (Croker, 2011). Health professionals need to provide services ethically and with integrity and communicate effectively with their clients across situations, cultures and languages. They need to adapt their interaction style to address clients' individual healthcare needs, priorities and goals within each workplace context (Higgs et al., 2012).

Reeves, Lewin, Espin, and Zwarenstein (2010) recommended training in effective teamwork, with greater flexibility at local levels to implement strategies that enhance the effectiveness of communication, relationships, teamwork and healthcare interventions. They also recommended increased awareness of existing structural and organisational influences including power relationships and hierarchies in the design and implementation of healthcare services, stronger consideration of the impact of these influences, and scope to implement changes to optimise healthcare relationships and outcomes.

Effective communication underpins all collaborative healthcare relationships and is the mechanism through which relationships are mediated and developed. Communication itself may be considered an integrating dimension which connects all the nested dimensions of Figure 7.1. In this chapter, we have considered the application of the social-ecological model to healthcare relationships and explored how these relationships are brokered and nurtured through the communication practices of the individuals involved.

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8. WORKING IN TEAMS

Where Is the Client?

> *I am unique. I am not a collection of symptoms and physical problems. I am more than the sum of my disabilities. My goals may not be your goals; things which you consider necessary to your very existence may be of little or no importance to me.* (Glossop, 2006, p. xii)

Teamwork and *client-* or *patient-centred* care are seen as desired attributes of health service providers. However, the relationships between the teams providing health services and the people receiving those services are made complex by the ambiguous nature of clients' roles in teams. What are their roles in the team? Are they actually part of the team? How visible is the team to them? How can they be involved in teams? This chapter draws on current literature and the authors' research to explore the concept of client-centred care, the role of clients in the team and implications for health service teams. While recognising a range of different team styles and contexts in healthcare, this chapter has particular focus on rehabilitation teams.

PLACING THE PERSON AT THE CENTRE OF HEALTHCARE

The importance of placing the person at the centre of healthcare is evident in key strategic documents of governments of nations around the world. Terms used interchangeably for this concept include *client-centred, patient-centred*, *people-centred*, *person-centred* and *consumer-centred*. What exactly do these terms mean? In Australia, patient-centred care is defined as care that "is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (Australian Commission on Safety and Quality in Health Care, 2013, para. 1). The Commission associates values such as dignity, respect and inclusiveness with patient-centred practice. The Health Foundation in the United Kingdom takes the concept further, identifying that person-centred health services support people to make informed decisions "about and to successfully manage their own health and care" (The Health Foundation, 2014, para. 1). This indicates the importance of people participating in their own healthcare, and of health professionals working in ways that enable people to be involved in decision making. The Health Foundation also identifies the need for health service providers to respond to the uniqueness of individual people, by being "responsive to people's individual abilities,

J. Higgs et al. (Eds.), Health Practice Relationships, 65–74.

preferences, lifestyles and goals". How do such concepts align with practice in healthcare teams? Can person-centred practice truly be realised in healthcare teams? And, in this quest, what do we call the people at the centre of healthcare?

Terminology describing people at the centre of health tends to reflect professional perspectives and individual preferences. When given the choice of the terms *patient, client, customer, consumer, partner* and *survivor*, a group of surveyed healthcare users identified patient as being least objectionable as it was "based on a model other than that between buyer and seller" (Deber, Kraetschmer, Urowitz, & Sharpe, 2005, p. 351). Another surveyed group of hospital patients also preferred the term patient to client or other titles (Nair, 1998, p. 593), commenting, "'client' implies business, 'patient' affirms the service nature of hospitals" and "'client' sounds too commercialised". However, the term *patient* has been strongly associated with acute hospital care and is not generally inclusive of community-based health settings.

In this chapter we use both terms. The term *client* encompasses concepts of a more active role than that implied by patient, and frames healthcare in teams as being relevant to contexts beyond hospitals. The term *patient* reflects participants' common usage in our research of rehabilitation teams.

CLIENT-CENTRED HEALTHCARE AND HEALTH TEAMS

The complex nature of health professionals working together in healthcare (see Chapter 9) risks clients being largely invisible in conceptualisations of teams, or marginalised in relation to roles and team processes. Evidence of this is the tendency for the *team* to be conceptualised in relation to the professionals *delivering* care, rather than clients. For example, relationships in teams commonly use the descriptors, "multi-", "inter-" and "trans-". Yet these descriptors relate to different ways health professionals work, with little bearing on the client. Although many authors use inter- and multi- interchangeably and inconsistencies in definitions prevail, common themes can be identified. The three descriptors can be understood in relation to a continuum of team processes, with *multi-* at one end and *trans-* at the other. The descriptor *multi-* tends to refer to different professionals who work separately and who either report information or share information. Essentially, for such authors the prefix *multi-* denotes the retention of role boundaries by the professions. The definitions that incorporate the descriptor of *inter-* exhibit the greatest variation, with professionals sharing roles (Masterson, 2002; Sorrells-Jones, 1997) or working separately (Stepans, Thompson, & Buchanan, 2002), retaining boundaries (Paul & Petersen, 2001) or merging (Masterson, 2002). It is only when *trans-* is used as a descriptor that consensus clearly appears with an emphasis on shared roles, role blurring and even role exchange. Notable across these definitions of teams is the absence of clients, which challenges notions of client-centredness.

Teams in healthcare, including rehabilitation, have a range of different processes and structures that influence the nature of interactions with patients. *Temporary task groups* and *informal networks* may be formed to deal with particular patients' situations. For example, professionals may form a task group to facilitate a client's transition from hospital to home. The structure and composition of such task groups depends on the needs of the situation. Composed of health professionals who may or may not have worked together before, they tend to be dissolved when the task is complete. Professionals in an informal network may be experienced in working together and communicate intermittently when the need arises, a particular patient often being the trigger for their interactions.

In addition to these informal collectives are *formal teams* caring for a number of different patients at the same time. Some of these teams, such as brain injury teams, have clearly delineated membership and boundaries. Individual health professionals are appointed to discipline positions and work in accordance with a team philosophy, documented roles and accepted ways of interacting. In other teams, such as rehabilitation teams in acute hospital wards, health professionals' discipline rosters and concurrent responsibilities to other areas of health services imply fluid team boundaries and dynamic team membership. Significant energy may be required by members of formal teams to embed the team philosophy into the team culture and maintain a sense of "teamness" in the face of ongoing changes. The energy and attention required by team members for team building and maintenance places team membership beyond the scope of most patients in acute settings.

Common to most rehabilitation teams are regular team meetings or case conferences where health professionals have the opportunity to establish understandings of the whole patient and set shared goals:

> [When] people actually physically meet face-to-face each week and share the information … I actually get a sense of the patient. [AC:P6, health professional]

> There's value for those meetings because we all need to know [information from others] for that patient's sake, in terms of planning their next week of rehabilitation and the week after that and the week after that. [AC:P22, health professional]

Yet such case conferences tend to involve health professionals talking *about* patients rather than *with* them.

Clients are often absent from common conceptualisations of responsibilities in formal teams. Team roles are usually framed in relation to individual disciplines (including doctors, nurses, physiotherapists, occupational therapists, speech pathologists and social workers) or to collective team responsibilities not directly related to clinical practice with clients (such as team manager and discharge planner). Teams may also assign a team member to the role of client liaison or case worker. This would appear to emphasise the separateness of the client from the team, in that a specific role is necessary to communicate on behalf of the team with the client and family.

CLIENTS' INVOLVEMENT WITH THE TEAM

To meet the challenge of considering patients as team members, our stance is that health teams need to have the client at the centre, with a collective of professionals working together with this client in the provision of healthcare. Was this evident in our research?

The type of team and the nature of the health problems treated can influence clients' involvement with the team. Patients could not be considered to have roles as *team members* in Julia's or Anne's research (Coyle, 2008; Croker, 2011). In Anne's research the complexity of what was involved in becoming a team member and contributing to the "teamness" of the collective (see Chapter 9) was beyond what could be reasonably expected from someone with a newly altered body in a vulnerable situation facing unknowns and uncertainty. Patients in rehabilitation faced overwhelming challenges related to their altered bodies:

> [When I was admitted] I was like in a bit of a state. I've had a stroke, [I didn't know] what was going to happen … next and where we were going and what was going to happen to me … [It] took a little bit of grasping, especially when you had to go to the toilet with somebody else to clean you … it took me apart a bit, and I did get emotional. (AC:P68, patient)

> I don't trust my own body half the time. (AC:P74, patient)

> [My husband] couldn't talk. He was totally paralysed down one side. He couldn't speak … He knew what was going on and it was very hard for him to try to communicate with anybody. (AC: P77, wife of patient)

Understanding different professional roles, integral to being a team member, was often difficult for patients.

> [My husband] didn't really differentiate between whose job was what … As he improved I think he more easily identified with what their jobs were. (AC:P77, wife of patient)

As explained by another patient, patients provide the purpose for health professionals to work together: "*They have to have somebody to work with don't they. They're not going to see results if they're sort of working with each other*". (AC:P71, patient). In such situations, patients need to be the focus of the health professional team rather than needing to take on responsibilities associated with being a member of the team. Ideally, being the focus of the team enables patients' concerns, aspirations and questions to be heard and taken on board by the team; thus patients can be heard without needing to be involved in "team maintenance". See Chapter 15 for a contrasting situation of a client-led home care team.

However, even when patients were the focus of and the purpose for rehabilitation teams, health professionals did not necessarily *collectively engage* with them. Collective face-to-face engagement between the team and patients took time and leadership. For example, in Anne's research, where patients in one team individually participated in rehabilitation case conferences, the leader of the team explicitly encouraged team members to talk *with* rather than *about* patients. This team leader actively ensured that team members interacted directly with the patient. If necessary he used hand actions to direct team members' attention to the patient, discouraged the use of discipline jargon and ensured that the pace of the meeting allowed for patient contributions.

In Julia's research, the only meetings to routinely involve patients were ward rounds in acute care and family meetings in the sub-acute care (Coyle, 2008). The level of involvement of patients in hospital meetings reflected their position within the system as people with relatively little authority. In acute care, ward rounds had a dominant medical focus. These meetings usually started at 7:00 am and involved the medical registrar and the residents touring the ward, stopping at each bed to discuss patients. Often patients were just waking up, or trying to finish breakfast, or getting washed. Routinely the team were observed discussing patients who lay between them listening to the conversation. The language used was distinctly medical, peppered with jargon and acronyms that would make it difficult for the uninitiated to understand. Although some team members greeted patients as they arrived at their bed, they did not usually engage patients in conversation until a decision needed to be relayed to them. Practitioners participating in this research adopted the doctors' lead when attending rounds. They used the same language and entered into discussions at the foot of each patient's bed, seeming to accept this as appropriate behaviour in spite of the issues it raises in relation to client-centred care.

A patient participant in Anne's research described his confusion at ward round interactions. He was unsure of etiquette: not wanting to exclude others in the group when he spoke to the main doctor, but not having been introduced to the team members he found it difficult to include them in discussions. Was he talking to one person or the team? The extent to which the patient's social discomfort impeded his interactions needs to be considered.

> I don't remember their names but I know there's Dr X and there was a young girl, and then there was like two other guys, that's the group of them. When there's more people in a room I find it more difficult to just talk to everyone, but if there's just an individual I can kind of just focus on what they are, feel as if you have to make eye contact with everyone or otherwise it seems a bit rude or you feel as if you have to talk to everyone in the room. You don't really want to make it seem as if you [are] talk[ing] with the one person. When the one person is sort of talking to you, you find it hard to kind of give the attention to the other people, but they didn't really seem to mind. They had their heads down in books anyway so it wasn't really that big a deal. It was almost like they were just there to kind of write down stuff. They didn't really ask me about too many questions, like it was more just Dr X that was kind of speaking to me. (AC:P73, patient)

Family meetings routinely involved patients (Coyle, 2008). A health professional participant in Julia's research described the meetings and their purpose:

> It's a good chance [for the family] to actually meet the team, describe what we do, describe their current status and what goals we're currently working towards. Then also to get that information from the patient, to kind of suss out what the family's goals are, what they would be able to provide in terms of support. It just depends on the individual case at the time. Sometimes we might get together as a team before we go into the family meeting and just clarify what the goals of this family meeting are. It might be purely to give information and to share the current goals, other times it might be for discharge planning and to target discharge as the main thing; make a decision about what's going to happen. This is their level of care. This is as much as we think we can provide at this stage. What does the family think about that? So we often have a bit of an agenda as to what we want to discuss. We have a proforma, and we usually go in a certain order. I don't know why, but the doctor usually speaks first, gives the medical information, and then physio, OT, speech, nursing. All the way through, the family are given opportunities to ask questions. We make it fairly informal. Then we all type in our sections on the computer and the social worker collates it and sends off a copy to the family. (JC:P13, health professional)

Like other health professional participants in Julia's research, this health professional portrayed the patient and family as a clearly delineated entity separate from the health professional team. Getting together prior to the family meeting enabled health professionals to establish the meeting agenda and control the flow of the meeting. A clear hierarchy was evident within this team, with the doctors in the lead and the patient on the periphery rather than at the centre. Interestingly although Julia sought permission from patients (during data collection) to be present during health professional team meetings where they were discussed, patients were consistently surprised to learn of these meetings and curious to know what was discussed (Coyle, 2008).

The hierarchical nature of health services played a significant role in the capacity for practitioners to advocate on behalf of clients, or for clients to speak up on their own (Coyle, 2008). Senior practitioners saw their role during these rounds as an advocate for the patient and to protect other services. Although less experienced participants shared the desire to act on patients' behalf they were less likely to speak up in the context of the ward round. Different behaviour was seen during data collection observations, with more experienced practitioners routinely querying or leading decision making whereas the less experienced rarely did so. However, less experienced practitioners did not usually passively agree to decisions they did not support, as they were seen to discuss the decision with the resident or the registrar outside of the round.

> The advantage [of attending rounds] is that they [other health professionals] sometimes say things to the patient and give a prognosis that maybe is inaccurate. Patients ask a question and they get an answer that isn't quite right. For example, last week we had, I think, four referrals for inpatient rehab for total joint surgery patients that were going smoothly. One guy had a

> 4-day length of stay yet they still filled in an inpatient rehab form on the second day. The patient gets confused about what's happening, the rehab [ward] get faxes that go on their files, they have to make the time to come and assess this person so it just wastes time. Whereas, if we're there we can say, oh no this person is well supported, previously fit, young, going well, good activity so leave it. (JC:P14, health professional)

As in other meeting situations, health professional participants' level of confidence in their knowledge and judgement influenced their capacity to speak up. Those with less confidence would tend to raise the issue in a safer way, informally with a single doctor. In Julia's research, health professionals spent time after rounds explaining to patients comments made to them during rounds. Although this did not alter decisions or provide patients with greater say, health professionals saw it as important for patients' understandings.

REALISING CLIENT-CENTRED CARE THROUGH TEAM PRACTICE

In this section we argue that even though clients may not be "team members", there is scope for their involvement in team discussions and decisions. However, patients have different starting points and capabilities for being involved in setting rehabilitation goals, particularly in relation to agency and health literacy. Health professionals need to be sensitive to these differences if they are to realise patient-centred care. The quotes below illustrate contrasting situations. Toni's admission to hospital was planned. She proactively chose her rehabilitation centre. She understood her medical condition, and was prepared to stand up to decisions she did not agree with.

> I waltzed in [to the rehabilitation unit prior to my scheduled amputation] … up to the desk and said, Well I'm going to have a leg off, can I come back here? … And that's virtually what I did say because I didn't know what to say to them. And then he took me to [another team member] and she then went on to explain how the ward worked because I knew nothing about the actual physio side of it or anything like that. I left very inspired … [Later after the amputation] I said [to the team member] YOU'RE NOT LISTENING TO ME! … We've had a real problem of how he [the team member] thinks my diabetes should be handled, and I have another way which I've been taught how to do it. (AC:P69, patient)

In contrast, other patients assumed more passive involvement, with minimal input to rehabilitation decisions, for example:

> I don't think (my wife) and I can (set goals). (AC:P68, patient)

> I just let them go along and do what they've got to do. They're doing a good [job to] make me better. (AC:P75, patient)

Patients such as these are reliant on health professionals picking up and taking the time to tune into subtle messages and “passing comments”. In Anne’s research, patients’ wishes and aspirations were often brought into team meetings through recounted snippets of their conversations with team members. These were particularly obvious when team members repeated verbatim patients’ words in “she said” or “he said” types of contribution. This added a patient-centred authenticity to the collective goal-setting in team meetings. These contributions often triggered responses from others, including recall of other relevant incidents. These spontaneous, often seemingly disordered interactions contributed valuable information for establishing shared patient-informed goals. The following quotes are examples of recounted conversations about different patients that Anne heard health professionals say during case conferences:

> He is very motivated. He said to me yesterday, I want to get home, I have been doing this so I can get as good as I can get.
>
> His walking looks odd; he brought that up himself.
>
> He is quite adamant that it is not going to happen when he gets home.

Each of these comments triggered further discussion about the patient’s future rehabilitation directions that was often integrated into decisions about goals and discharge dates. To really hear and make sense of these messages requires the team to have time, flexibility and the ability to engage with and assimilate stories and snippets of information during team meetings.

If patients are to be offered the opportunity to have their voices included in case conferences, directly or indirectly, they need to be aware of the existence of such meetings. In contrast to community settings, where patients’ permission tends to be obtained prior to discussing them with others, in hospital and rehabilitation settings permission tends to be assumed. In the absence of formal permission processes, the value and courtesy of letting patients know that they are being discussed at team meetings may be overlooked. This is particularly relevant for patients who seek passive roles or those who are overwhelmed by the nature of their illness … In the next example a patient who had previously worked in rehabilitation teams intentionally used the meeting to ensure her voice was heard at the meeting even though she was not present. By using health professionals as “proxies”, her goal became the team’s shared goal.

> [The team was] not so [visible] physically though I was aware that team meeting would happen every week … I wasn’t invited. You know, patients don’t go to that meeting. They have the meeting and then they do the ward rounds … I took the initiative, knowing that they were getting together, having a meeting. I told a variety of people (my goal) so they would all say, Oh yeah, yeah she said that to me too. I was using their process to try and facilitate my point of view. (AC:P72, patient)

CONCLUSION

This chapter concludes with a free text evoking a sense of a team meeting where patients' voices are brought to the meeting, or maybe not.

TEAM MEETING

"Next patient …"
Health professionals gathering to
listen, contribute, question and clarify.
Seamless decisions, unspoken agreements.
Written, recorded, regulated.

Then … an unexpected addition …
"But he told me he wants to go home for the weekend".

The team meeting's conveyor belt falters.
Anecdotes, stories and snippets surface
besieging the order, the plan, the jargon.
Overlapping and unfolding conversations,
triggering recalls from others.

"She said … he said … they think …"
Other voices, though not present, are clearly heard.
Patients' voices. Their families' voices. Their friends' voices.
Proxies informing team decisions.
Perspectives alter, plans evolve.
Shared visions for future action emerge.

Yet measured commitments of recorded decisions
belie the depth of narratives just shared.

But … when,
(perhaps through time pressures or team changes)
their conveyor belt maintains its momentum,
are their patients' voices drowned by
the mechanistic rhythm of discipline jargon?

"Next patient …"
They listen, contribute, question and clarify …
Stories and banter,
and patters …

Text Box 8.1. Free text poem (Croker, 2011)

Current health team practice could be seen to constrain our ability to fully realise client-centred care. Despite this, when team members are attuned to their clients' needs and alert to opportunities to centre their attention on their client, teams can be client-centred in their approach. A cultural shift is necessary for teams to truly embrace client-centred practice and demonstrate the values of dignity, respect and inclusiveness associated with a client-centred approach.

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9. COLLABORATION AND COLLABORATING

People working together and interacting with each other is central to health practice relationships. Clinicians do not work in isolation; they work with patients and their carers, colleagues, other healthcare professionals and community services. Without collaboration healthcare services struggle to be effective, timely, safe and appropriate. In this chapter we are focusing on the notion of collaboration and the acts involved in collaborating as part of health practice relationships. Based on doctoral research (Croker, 2011), we will explore the lived experiences and humanity of collaboration. While the health literature often presents relationships as ordered, controllable and measurable, those involved in collaboration often describe relationships as messy, evolving and unpredictable. This was the case in Anne's doctoral research (ibid.). In this chapter we argue that in human healthcare systems contexts, the privileging of the visible, measurable, predictable and controllable by management should be questioned. Greater appreciation of the need to recognise the variability and importance of individual human interests, approaches and needs is essential to make collaboration truly effective. While recognising the importance of the role of patients and carers in collaboration, we focus on collaborative relationships among health professional team members as part of the delivery of patient-centred care.

BACKGROUND

From a structural perspective healthcare systems are built around teamwork, from a small group working directly with patients to increasingly complex departments and administrative frameworks. *Collaboration* encompasses the notion of people working together for a shared purpose. It could be expected, then, that collaboration is desirable and pursued at all these levels. However, despite its accepted value to enhance working towards shared purpose, collaboration between health professionals does not necessarily happen easily and routinely in healthcare. Many factors in the real or clinical world compromise genuine collaboration. Consider, for instance, the impact of time pressures, staff shortages, organisational structures, reporting requirements, obstructive workmates and different expectations.

Embedded in the stories and literature of people working together in healthcare situations, are different conceptualisations of collaboration. The manager of a hospital, who views collaboration in terms of efficiency, seeks to assign a dollar value to collaboration. A health professional, who represents a particular discipline and deals with different discipline territories, professional boundaries and individuals, is enmeshed with the interpersonal and political intricacies of collaboration. The educator, who seeks to prepare novice practitioners to deal with the demands and

J. Higgs et al. (Eds.), Health Practice Relationships, 75–84.

uncertainties of working with others, is also required to evaluate and assess students' capabilities for collaborative or interprofessional practice in the future. At the centre are the patients and their carers, who can be overwhelmed by the challenges they face with their newly altered bodies and interrupted lives: they are both the focus of the healthcare team's collaboration as well as participants in their care.

Due to different meanings given to the phenomenon of collaboration many questions are raised: "Do these variations in meaning represent different parts of the same phenomenon?", and, "if so what does the 'whole view' of collaboration look like?" To answer these questions, Anne's doctoral research, reported in this chapter, undertook an exploration of the "whole view" of collaboration. It aimed to see what collaboration looked like from different perspectives.

EXPLORING COLLABORATION AND COLLABORATING

Exploring the abstract phenomenon of collaboration (as a concept and noun) and the experience of collaborating (as an action and verb) provided a framework for understanding the multifaceted and interrelated nature of "knowing about" collaboration and the experience of "doing it". Higgs and Horsfall (2007) explain in Text Box 9.1 how nouns and verbs contribute different ways of viewing a phenomenon. As the act of collaborating involves *people* engaging with each other, including this notion strengthened the person-centred stance of Anne's research.

nouns are abstractions, symbols *promoting vision,* *representing things* *that are widely accepted* *they are more general, passive* *and distant, more finished*	*verbs are active* *immediate, particularised* *and person-based* *they represent experiencing and* *understanding of being in the midst* *of the lived experience*
	(Higgs & Horsfall, 2007, p. 239)

Text Box 9.1

The research involved two studies. In the first a philosophical hermeneutics approach was taken to explore collaboration (the noun). A set of texts from an array of organisational, educational, research and healthcare literature was constructed and then systematically interpreted. The second study was a hermeneutic phenomenological one exploring the experiences of collaborating (the verb) in rehabilitation teams. See Croker (2011) for more detailed explanations of the research methods used in the research. The key findings arising from these studies and the model developed will be explained in the remainder of this chapter.

STUDY 1. COLLABORATION: *ORDERED* AND *ORGANIC* MODES

From the first study (analysing texts from the literature) collaboration was interpreted to involve *ordered* and *organic* modes of working with others. *Ordered modes of collaboration* (such as would occur in formal teams like appointed ethics committees or in meetings of healthcare service department heads) are driven by efficiency, cost-effectiveness and discipline power relationships. These modes emphasise what is predictable, replicable and measurable. The often less explicit *organic modes* (such as might occur with an outpatient clinic area where variable groups of practitioners are rotated through this work area) are founded upon relationships and mutuality between people rather than being led by bureaucracy and systems. These *organic modes* of collaboration enable the inherent uncertainties of the people-focused dimensions of healthcare to be embraced and provide scope for dealing with the different collaborative needs that arise from the many different situations that people encounter in healthcare.

Four domains were interpreted to operate across these ordered and organic collaboration modes: *place* (the situation of collaboration)*, people,* (those involved), *purpose* (the goals or intended outcomes) and *process* (ways of communicating and interacting). These domains provide a framework for understanding the characteristics and implications of *organic* and *ordered* modes of collaboration, see Table 9.1.

Table 9.1 Characteristics of ordered and organic modes of collaboration

Dimensions of collaboration	**Ordered modes of collaboration**	**Organic modes of collaboration**
Place	Collaboration occurs in teams with stable membership and discernible boundaries that are isolated from complexities of context.	Collaboration occurs in evolving networks, informal groups, teams of varied nature that are part of a wider societal context.
People	Team members represent discipline clinical roles and organisational roles.	Team members are seen as unique individuals with varied socialised discipline characteristics and personal and professional experiences.
Purpose	The drive for collaboration is externally established. Coordination and integration are sought.	The drive for collaboration originates internally. Synergy, innovation and learning are sought.
Processes	Interactions are directed predetermined, trainable, reproducible, measurable.	Communication and interactions are opportunistic, evolving, situationally specific and based on developing relationships.

i) Ordered Modes of Collaboration

Ordered modes tend to focus on collaboration within demarcated territories, such as teams with clear boundaries and stable memberships. The context of collaboration is circumscribed. In these settings collaboration can be planned for, monitored and measured, and tends to be isolated from complexities of context.

In *ordered modes* relationships between individuals are not necessarily visible or prominent. Rather it is the amalgamations of people and collective entities that are easily seen. Collaboration occurs, for instance, between disciplines, organisations, agencies and other groups. The focus is removed from particular individuals who are interacting and placed on the role of entity the individual represents (e.g. discipline). In doing so it is typically the socialised characteristics of the role or entity that are valued in *ordered modes* of collaboration, rather than interpersonal characteristics of individuals.

Collaboration in *ordered modes* tends to be externally instigated. Responsibility for initiating collaboration lies with others, often through policy changes and management directives. Financial incentives can be used to encourage those involved to participate in the collaboration. The outcomes of the collaboration are often predetermined, for instance the expectation that the group will produce items such as strategic plans, team budgets, or patient management plans. Prescribed or expected patterns of interaction, such as following meeting procedures, tend to dominate collaborative processes in *ordered modes.* These structured and predetermined interactions provide predictable means of communication, for example regular team meetings and clear lines of communication. Having a framework to guide and monitor interactions can be beneficial in lessening the impact of disruptive or negative factors; for example a team meeting agenda can schedule time for all team members to have input, regardless of the person's position in the team's hierarchy.

ii) Organic Modes of Collaboration

In contrast to *ordered modes of collaboration*, aspects of *organic modes* tend to be less visible to those outside the collaboration. Evolving networks, informal groups and loosely structured teams are a common context for *organic modes* of collaboration. These groupings are woven into and across their wider organisation and societal environments, with organisational structures, discipline traditions, social issues and interpersonal factors shaping the nature of the group and interactions. Being embedded in wider social and organisational contexts, collaboration in this mode is influenced by contextual factors, for example individual preferences and capabilities, community values, financial constraints, and organisation and discipline cultures and territories.

The unit of interactions within *organic modes* of collaboration is largely the individual (or perhaps small groups or partnerships). Although individuals might represent a discipline, department, organisation or agency, interpersonal interactions are the focus of *organic collaboration*. In this mode, particular individuals bring their personal qualities as well as the perspectives and conventions from their organisation and their discipline socialisation.

Collaboration in *organic modes* tends to seek synergistic outcomes that are not particularly predetermined. The outcomes can be unexpected and creative. They are often internally instigated, resulting from individuals identifying common purposes and taking initiatives. Such collaboration can originate when individuals seek to work together and take responsibility for doing so in a mutually advantageous manner.

Communication strategies are variable, following individual and group preferences, rather than being expected or prescribed as in *ordered modes* of collaboration. These strategies are founded on personal qualities, such as willingness to work with others, respect, trust and mutuality. They require resources such as time and proximity and can respond to rapidly changing situations.

Figure 9.1 depicts a diagrammatic portrayal of ordered and organic modes of collaboration. In this diagram the organic mode of collaboration is represented by the inner, subtly shaded triangles and black font for labels, and the ordered intention is depicted by the more definite shades of the outer triangles and white font for labels.

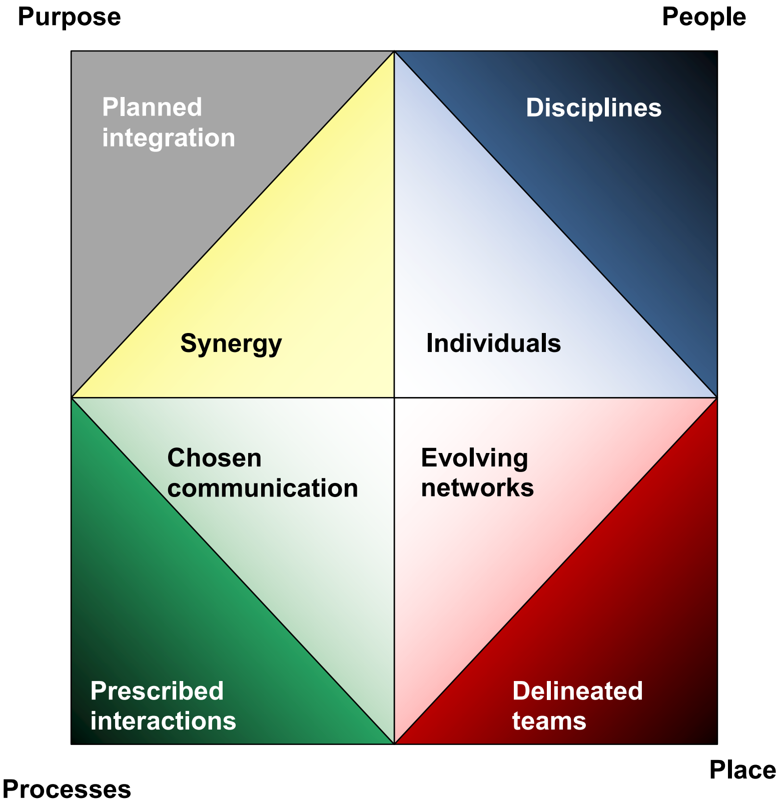

Figure 9.1 Ordered and organic modes of collaboration

iii) Value and Limitations of Different Modes of Collaboration

Based on this interpretation of collaboration, ordered modes of collaboration typically demonstrate organisational commitment and support in terms of structures, frameworks and resources. However, an over dependence on ordered modes with their focus on measurable and predictable aspects of healthcare (systems) could lead to support for mechanistic systems in which relationships between individuals are largely unrecognised and repressed. Concentrating on discipline characteristics could overshadow the individuality, cultures and contexts of the individual people within the discipline, and seeking to protect professional territories can narrow the collaborative focus. When preferable, using organic modes of collaboration (particularly in more informal or transorganisational situations) brings the benefits of increased focus on individuals and their interpersonal relationships to provide a more versatile and person-centred rather than task-centred frame of reference for people who want (and pursue) choice and agency to interact and work responsively with each other. However, a sole focus on individuals could risk collaboration becoming meaningless to wider organisational purposes, being inadequately resourced, or having an undue focus on the "wrong" people (e.g. staff instead of patients). In essence, both modes are needed.

STUDY 2. COLLABORATING: ENDEAVOUR AND REVIEWING DIMENSIONS

In Study 2 of the research, the lived experience of collaborating was explored in rehabilitation teams; these settings representing (ideally) patient-centred, team-facilitated endeavours undertaken within healthcare institutions. Health professionals from a range of rehabilitation teams across rural, regional and metropolitan settings, participated. As well as more "ordered" integrated teams with managers and budgets, there were also less defined teams that were "organic" in nature, as explained in the following quotes: "The rehab team is very sort of vague here … It is not a defined boundary" [P72]; "There are not a lot of structured processes" [P17]; and "I don't really feel that there's anyone who sort of stands out as the leader of the team" [P71].

By exploring the experience of *collaborating* across this range of rehabilitation teams, the research was able to illuminate what happens across the boundaries of *ordered* and *organic modes* of collaboration. In doing so, the process and experience of collaborating was seen to involve five *intentional interpersonal endeavours* and three *reviewing (meta) behaviours* to monitor the nature and success of one's behaviours or endeavours in the pursuit of effective and person-centred collaboration, as shown in Text Box 9.2. The dynamic, layered and responsive nature of collaborating integral to these dimensions is illustrated in the quotes below:

> So if someone [a patient] is being seen by all the people who they need to be seen by, and all of those people are communicating, and are aware of all the other problems and issues that are going, and everyone has a clear idea of what everyone else thinks and where we're headed and what we need to do to get there, and you can help each other out, make suggestions to each other and pick up on problems that other people might have missed, that sort of thing, [then] I

> think it can only benefit the patient and their family if you're working towards that together. [P1]
>
> Different teams work in different ways and one thing might work in one place but [in another team] it doesn't seem to work as well. There doesn't seem to be an absolute model [of working together] that fits everywhere. [P45]
>
> Getting to know the system and how to approach people was a little bit daunting. [P40]

Participants did not experience collaborating as static or predictable but rather as a response to people (team members, patients), situations and organisational influences.

Endeavour and reviewing dimensions of collaborating

Dimensions of interpersonal endeavour

- ***Engaging*** positively with each other's diversity (which is accompanied by a respect for others and a willingness to learn from or manage differences);
- ***Entering*** into the form and feel of the team (which is influenced by the nature of people's entry to teams, together with their personal experiences and role expectations);
- ***Establishing*** ways of communicating and working together (where interrelated use of a range of structured and opportunistic communication is required);
- ***Envisioning*** together patients' rehabilitation frameworks with others (where clinical information is often interwoven with stories about the patient's situations and aspirations);
- ***Effecting*** changes in people and teams (which relates to working with others in organisational contexts to effect change in patients' capabilities, to deal with system requirements and to develop and sustain teams).

Meta-behavioural reviewing dimensions

- ***Reflexivity*** involving critical reflection and development of self in relation to others
- ***Reciprocity*** enabling collective mutuality to develop healthcare roles
- ***Responsiveness*** facilitating situationally appropriate and contextually relevant adjustments.

Text Box 9.2

See Croker, Trede and Higgs (2012) for quotes illustrating these dimensions.

The dimensions of collaborating provide a sense of the temporal (time) and situational (place) elements of healthcare practice. Views and experiences of collaborating are never “whole” or complete; rather, they are like snapshots that capture a particular perspective in a moment and situation. There is scope in the *experience* dimensions of collaborating for embracing the changes that team members bring about and that organisations require.

RESPECT MODEL OF COLLABORATION

From the findings of this research on collaboration (as a noun) and collaborating (as a verb), a model was developed, embracing the *ordered* and *organic* modes of collaboration together with the endeavour and reflexive dimensions of collaborating. This model is the RESPECT model, coined by Anne and her supervisors, to highlight the key ingredient and purpose of good collaboration and to represent the findings of this research that collaboration and collaborating is about:

R	*Reflexive*
E	*Endeavours (in)*
S	*Supportive*
P	*Practice (for)*
E	*Engaged*
C	*Centred-on-People*
T	*Teamwork.*

This model is depicted diagrammatically in Figure 9.2. This model captures and combines theoretical and organisational concepts of collaboration with the dynamic experiences of collaborating in a context of ongoing change. Respect encompasses intentions, attitudes and behaviours towards people (including the self, others involved in healthcare, patients and carers) and their diversity (such as discipline knowledge and socialisation, capabilities, experience, needs, fears and aspirations), as well as the uncertainty, complexity and specificity of the situations they face.

This model positions the temporal and iterative nature of collaborating (as represented by the circular motion of the meta-behavioural *reviewing* arrows and the fluidity of the *endeavour* dimensions) within a clearly shaped composite, systematic view of collaboration. *Ordered* modes of collaboration (with outer darker triangles), and the less visible *organic* modes of collaboration (in lighter shades) provide the framework upon which (through *endeavours* and *reviewing*) the collaborators “dance and weave” their unique collaborating pattern to suit the context, situation and people.

The RESPECT model presents collaboration as actively engaging-entering-establishing-envisioning-effecting together to achieve person-centred teamwork and collaboration for the provision of patient-centred healthcare services which occur within the context and framework of people-places-processes-purposes and operates in a way that requires meta-cognitive and meta-behavioural pursuits of reflexivity-reciprocity-responsiveness. In summary, collaboration is inherently about RESPECT.

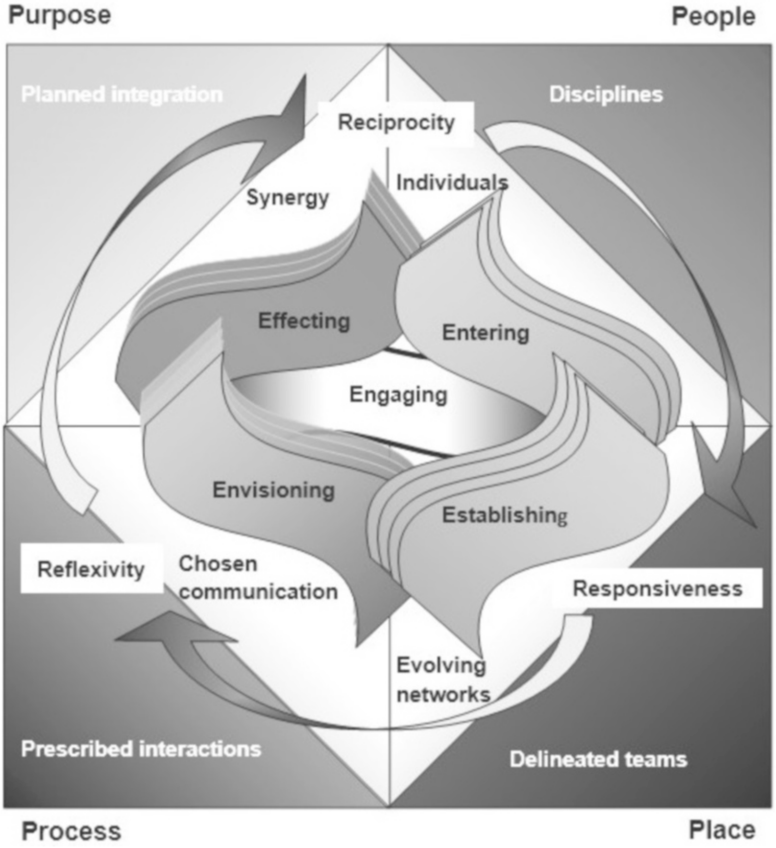

Figure 9.2. The RESPECT Model of Collaboration

USING THIS MODEL IN PRACTICE

The RESPECT model can be used as a guide to both establish new health practice teams and evaluate the processes and products of existing teams. It is most effective when it is applied at macro, meso and micro-levels simultaneously. At the macro level, while focusing on the *ordered* modes of collaboration, managers can become aware of the need to also enable *organic* modes of collaborating. Time needs to be allowed for teams to engage with each other and establish how they can best collaborate. At the meso level, team leaders will find in the RESPECT model useful reminders to encourage and model collaborative health practice relationships grounded in responsiveness, reflexivity and reciprocity. At the micro level, the RESPECT model is a guide for health professionals to focus on and value interpersonal professional relationships. People at all levels should keep sight of what is probable and possible within given healthcare structures and ordered models of collaboration. Realisation of the full potential of the RESPECT model requires each level of organisation and each team member to work genuinely towards shared purposes and goals, learning from experiences to continuously improve collaboration and collaborating. All domains of this model need to be kept activated and deliberate decisions need to be made on how to proceed in each clinical situation. Respect cannot be demanded, but it can be earned.

CONCLUSION

Collaboration and collaborating are complex phenomena. Even with increasing conceptual interest, research and policy support collaboration can remain an elusive concept for many health professionals and patients, and those involved in collaborating can find the experience intensely interpersonal and dynamic. In this chapter we have argued that healthcare systems and practice require both *ordered* and *organic modes* of collaboration The RESPECT Model of Collaboration provides a contextually relevant and situationally appropriate basis to inform the development of collaborative relationships that embraces organisation support for robust yet responsive and respectful collaborating relationships.

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10. PEOPLE CARING

Negotiating the Space between an Ethic of Caring and Keeping Your Distance

Caring means … feeling or showing care and compassion
(Collins English Dictionary online)
… displaying kindness and concern for others (Oxford Dictionary online)

My first full-time job was as a direct care worker in a residential facility for children who had severe and profound intellectual disabilities. On my first day two things happened: firstly the manager took me into the office and told me not to get too involved with the clients, to keep my distance, it was better that way. Then I was introduced to the group I had been assigned to work with: four children ages 8 to 16, three boys, one girl. Brendan, with blonde hair, large blue eyes, perfect skin and a permanent smile on his face; David, green eyes, freckled skin and a sprite-like personality; Jimmy, brown wavy hair and a wicked sense of humour; Julie, the oldest of the four, permanently miserable unless winking at one of the male staff. Spina bifida; cerebral palsy; severe autism; diagnosis unknown. Three wheelchairs, no language. I worked hard to get my co-workers to give them some privacy by shutting toilet doors; to give them some dignity by removing the plastic bibs that hung permanently around their necks, albatross like; and to give them some control by designing basic communication systems. Thirty years later they haunt my dreams. Brendan walks onto the bus, Julie tells me to f*** off (something I guess she always wanted to say; I was not her favourite), Jimmy eats a whole meal in a café by himself and David speaks to me about his life and loves. I suspect they made more of an impression on me than I did on them; I doubt they have dreams about me as a middle-aged woman. (Debbie)

Being clinical: The traditions of health and social care lie in such places as battlegrounds and extreme poverty born of industrial revolution, pestilence and other dramatic historical events. And these origins are reflected in the culture of these human services through battles between caring and scientific advances that called for knowledge of germs and sterile procedures, between philanthropy and the need to be fiscally accountable, and between doing good unto others and being on the "deserving poor" list. The words we use match these conundrums: clinical, for example, reflects healthcare and places of healing as well as being

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> objective and distant, professional, disinterested. I was told – yes, develop rapport with your patients – that is the way to gain their compliance – it was meant to be professional and objective – a task-oriented not people-focused rapport. (Joy)

There is something quite perverse and disquieting about telling people who enter the caring professions not to care too much, to keep their distance. There is something predominantly bureaucratic and dollar-driven about health and social care systems that emphasise efficiency, cost accountability and practice drivers such as empirical research grounded in principles of population consistency and exclusion of contextual considerations. As the definitions at the start of this chapter show, caring is both about feeling and then acting on those feelings in relationship to some other(s), and it is about people working with people in consideration of their individualities and their situations.

We are particularly interested in raising the following questions. How do you care if you keep your distance? And what is this keeping your distance all about? What effects does this narrative have on the construction of care work and care workers, whether they are nurses, social workers, home care workers or physiotherapists, for example? Where does humanity fit into the essentially human professions? How can an ethic of care, based on relationships, be reinvigorated in practice? What is the place of professional development in engendering an ethic of care? In this chapter we explore these questions using our experiences and the experiences of others via research concerning the *caring* in health and social care.

We turn now to three qualitative research projects focusing on caring: the caring at end of life research project; the care networks project; and the caring journeys project (Horsfall, Blignault, Perry, Antonopoulos, Bridges, & Zogalis, 2013; Horsfall, Leonard, Evans, & Armitage, 2010; Horsfall, Leonard, Noonan, & Rosenberg, 2013; Horsfall, Noonan, & Leonard, 2012). These projects explored the roles of formal and informal carers and the relationships between the two in end of life care and care of the frail aged. Formal care workers are people employed to provide care, such as nurses, GPs, physiotherapists, and volunteers auspiced by an organisation, while informal carers are friends, family, neighbours, and work colleagues of the person being cared for.

When listening to the stories of formal carers, and later analysing the data, it became clear that the "caring while keeping a distance" narrative caused formal care workers pain. They felt caught in a conundrum. To survive they chose one of three responses: (1). Comply and either deny the conundrum or feel powerless; (2). Recognise the conundrum and disobey the rules; (3). Negotiate the space between caring and keeping a distance. The stories and data showed quite clearly that health professionals, or the formal networks, made decisions to comply, resist, or subvert institutional caring relationship constructions. Threaded throughout the stories were issues of power and authority. We found that people with less positional power were more likely to comply. Those who took the second response were often community nurses who had their own geographical areas to work in and in many ways operated as "lone rangers". Care workers who were able to occupy the space in between caring and keeping a distance either had significant caring experience as "lay people" or had high levels of positional power, such as a palliative care consultant or the head of a nursing unit.

From the informal carers' perspective, care workers who either broke the rules or creatively bent them were the ones who they most appreciated, felt most helped by and often continued in relationship with. They talked about care workers who "*went above and beyond*".

> I know certainly the community nurses in P. with the soup run that they do every weekend is not part of their paid things … I would bet the huge majority of those workers will do above and beyond what they do in their allocated time.[1]

When we asked what they meant by "*above and beyond"* it was often something quite simple: dropping off medications on their way home from work, staying an extra 5 minutes to finish a cup of tea and have a chat, or changing a light bulb as the client could not climb on a chair. While some health professionals described such action as "*working beyond*", others clearly believed that it was breaking the rules.

How do these seemingly simple ways of being, of doing the job that needs to be done, come to be constructed as "*above and beyond*" by clients/community carers and as "*breaking the rules*" by those entrusted with policing institutional policies and procedures? One way of explaining this phenomenon is through the lens of new managerialism. It would seem that health service providers' work profiles are constructed to relate to clients and community carers in the climate of new managerialism and risk management. This has effects both on the provision of care and on the workers' emotional lives. New managerialism is imbued with defensive and prescriptive performance management techniques with a focus on audits, risk assessment, performance management, and adherence to rules and regulations. *These are the guidelines, this is what you do, this is what you don't do* (SPFG 2). It has led to a pervasive workplace culture of "monitoring and surveillance" (Lees, Meyer, & Rafferty, 2013, p. 550) with all the associated red tape. The effect is that there is less time with clients and a "splitting up" of relationships (Lees et al., 2013, p. 551) as these are messy, contextual and emotion-laden. Indeed, Lees and colleagues argue that this splitting was one of the primary reasons for new managerialism that sought to manage the risk to the worker, and hence the institution, of the effects of the messy, complex and often emotionally challenging work of health and social care workers, whose:

> primary task was the responsibility of caring for sick and vulnerable people, some of whom did not recover. Nurses had to deal with the realities of sickness, suffering and death, giving rise to strong feelings within nurses of pity, compassion, love, guilt, anxiety and even hatred. (findings from the Menzies Lyth study, 1988, in Lees et al., 2013, p. 544)

To manage this risk the institutional response could have been to provide support, supervision and perhaps counselling for health service workers, to implement strategies for helping people to integrate their tasks and the difficult emotional work entailed in their professional lives (such as in the counselling profession, where all practitioners must themselves have professional supervision); or they could deny the necessity of the emotional work by putting in place policies and procedures that minimise the risk that anything emotional will happen, thereby strengthening the "keeping your distance" narrative. The response was the latter. Rather than help deal with emotions, the present managerialist system of governance in health and social care has resulted in systems that entrench emotional distance from clients. And this strategy has been effective, as one palliative care worker said, "You've got to be careful because they die on you. You'd like to get more involved but you can't". The effects of this being careful, of not getting involved, are keenly felt by clients and their carers/families:

> I can remember John saying … they would talk about him but not to him … they'd treat him like that mandarin … They treated him basically at times like he was in a coma and wasn't aware of what they were doing.

In the two quotes above, health professionals deliberately sought to protect themselves emotionally. The person in the first quote did this by maintaining a distance, as "they die on you". In the second quote, the professionals looking after John, it would seem, were also protecting themselves and were so distant that they treated him as if he was in a coma. Clearly though, the effect of this distancing care was that John felt dehumanised, like a mandarin.

There are many paradoxes inherent in this type of governance of caring. On the one hand, professionals are instructed to maintain a professional distance with clients; on the other hand, the human contact is the greatest reward that they gain from their work (Leonard, Johansson, & Horsfall, 2012). And it is these paradoxes that cause the pain we referred to earlier. Part of this is due to the fact that the very roles of healthcare workers and their ability to provide good care are tied up with "sensing the needs of others … compassion, generosity, unconditional positive regard and presencing" (Stepney, 2012, p. 3). These qualities are essential to an ethic of care which is a relational ethic (Gilligan, 1982). Many healthcare workers recognise this: "It's about relationships and attitude". Furthermore, they are able to speak about what this type of care means; they can operationalise it, as the following quote shows:

> Good communication, building up rapport and relationships. Checking back. Keeping to your word. If you say you'll ring them back, you ring them back. You network with their family, you ring that family … that's all part of your duty of care and your individual planning for everyone that's in front of you.

People often continue in care work because they are committed to the values of caring guided by this ethic of care which privileges the individual, unique needs of the care recipients. This type of caring is only facilitated by closeness and relationship. The foundational value of an ethic of care is that all people should be treated *well*. Members of the community do understand that health and social care workers do a difficult job, and they tailor their expectations of them. However, they do not expect the effects of keeping a distance to compromise good communication and caring:

> And I mean I can understand it – I couldn't do their job. It would be a hard job and I can understand that they can't become emotionally attached to their patients … but they can be compassionate and they can show empathy. They can show respect … don't dehumanise the person. Don't dehumanise the carer … some of them are just so technical and they're not actually hearing it from a patient's point of view and from a carer's point of view.

New managerialism privileges an ethic of justice which is objective, rule-oriented and based on the notion of fairness and equal treatment. The foundational value of an ethic of justice is that all people should be treated the *same* (Leonard et al., 2012). From this perspective one can only provide the same treatment by keeping a distance. Practice becomes solely evidence-based, rather than a combination of relationship and evidence. Of course, both care and justice ethics are important in the provision of caring services. However, the effects of new managerialism, with its focus on correct rules, procedures, training and accountability, mean that context, relationship and individual qualities and skills, which are the foundation of relationships, are undervalued. This can lead to tension for care workers, who are often aware of such paradoxes. The first example below highlights the paradox of privacy policies and the second shows that relationships can often make it difficult for workers to obey the rules:

> You can't come up to me and say, *How's your wife?* It's up to me to raise it and yet in mental health I've got a team of 20 who will sit down on a case discussion – does the client realise that? Probably not.
>
> These are the guidelines, this is what you do, this is what you don't do … there might be a natural flow into something that they shouldn't actually be doing but because they have a good relationship with the carer or the person that's dying, it's hard for some people to say, *I can't do that.*

Negotiating these tensions and paradoxes can result in the pain we spoke of earlier which is both professional and personal: "Society grants a profession a monopoly over their area of expertise because the implicit assumption is that these people can meet the needs of the public better than any other group" (Stephany, 2012, p. 90). However, rigid hierarchical systems and management styles that rely on a "one size fits all" set of procedures and policies do not enable professionals to exercise their professional judgement. This means they are often constrained from acting in the best interests of their individual clients. Consider the following statement from a palliative care nurse:

> I see a lot of people that should have gone home and had those lovely experiences, never get the opportunity to. They're hooked up in the hospital system for too long, when as a nurse, blind Freddy can tell you they haven't got a long time but that conversation hasn't been made from the treating doctor … so people are still clinging on and clinging on and clinging on and I feel that we've failed them miserably in a lot of cases.

The use of repetition "*clinging on and clinging on and clinging on*", the phrase "*blind Freddy*", and her stated sense of failure show a sense of frustration and professional pain. According to the hospital procedure it is up to the treating doctor to have the difficult conversations with people. When they do not, however, the nurse feels constrained from doing so, even if she has years of experience and good communication skills. This is an example of the first response we mentioned above: comply and feel powerless. It also shows quite clearly that the nurse is affected – the protocols have not made her *feel* less; she is not distant. Instead, she feels she has miserably failed a lot of people. The rules and regulations that constrain her behaviour in this example have also impeded good patient care (Fonn et al., 2001). Managerialism can lead to "imbalances in practice that impinge on professionals' abilities to exercise professional judgement and act in the best interest of their clients" (Lees et al., 2013, p. 552), as the following quote shows:

> Our hands are often tied because what will happen is that we'll get people on the periphery who contact us and say, *Joe Bloggs at no. 6 Smart Street really needs some help. Can you please do something – this family's falling apart* and we're stuck in a situation where we have to say, *I'm terribly sorry. If Joe Bloggs hasn't committed to this* referral and he hasn't consented to this referral, we're not able to do anything.

Here the worker is constrained and frustrated by rules about privacy and the referral process. They feel they can do nothing, even though a concerned community member has said the family is "*falling apart*". This professional accepted being forced to do nothing, with hands tied. In the same focus group a more senior health professional offered an alternative response to constraining rules. She said that if someone asks how "Mrs so and so" is, to protect her privacy she simply says, "why don't you take them a cake or something, they would appreciate that". In this way she is exercising her professional judgement, building and encouraging caring relationships rather than shutting them down, thus acting in the best interests of her client, herself (as she is breaking no rules) and the community by showing how caring relationships can occur. This is an example of the third response, occupying the space between caring and keeping a professional distance. This response, we found, was more possible for participants who were not limited by governance issues, usually people in positions of more rather than less institutional power, and/or who had personal experience of being part of informal caring networks. Negotiating the space between caring and keeping a distance often entails bending the rules and privileging relationships, operating from an ethic of care (Leonard, Johansson, & Horsfall, 2012), for instance:

> We sort of go out of the boundaries if you know what I mean … If that was your mum you'd want somebody to treat her like that, so that's what we do. You go that extra mile. And that extra 20 kilometres – well, if somebody's dying and they live 25 kilometres, we just go.

This community nurse is someone who enacts and embodies a relational form of caring. She is transcending the limiting binaries which managerialist organisations seek to entrench and she does this through enacting empathy, *if that was your mum*. Bending the rules and privileging relationships are consistent with an ethic of care rather than an ethic of justice in service provision. Stephany is quite clear that this nurse is acting correctly, that client care comes before the institutional policies. “If an institution’s policies violate nursing values and ethical responsibilities … the delivery of safe, competent, compassionate and ethical care comes first” (Stephany, 2012, p. 104).

Professional development, both formal and informal, plays an important role in shaping practitioners’ approaches to dealing with the people spaces of health and social care. Pre-entry students learn from their practice role models, and from the spoken and unspoken rhetoric and inherent values of their curricula. After graduation, peers (particularly those in the same boat of facing the reality shock of independent professional practice) and mentors can strongly influence the choices practitioners make, the professional identity they come to own and the strategies they use in realising their practice relationships. We need to remember that practitioners do not necessarily launch into their early years of practice with well-developed ethical frameworks and strategies for dealing with practice relationships and pressures. We need to realise that

> [professional] acculturation occurs inevitably and novices or newcomers entering the workplace, profession or team are drawn into the culture, learning from existing members/staff what it means to be a member of the group. This places responsibility for the success and quality of work teams and client outcomes on the shoulders of incomers, insiders and system managers. Professional socialisation should not be left to chance. Newcomers should not be left to swim, sink or drop out of the system. Rather …, professional socialisation should be a collaboration in good practice evolution. (Higgs, Hummell, & Roe-Shaw, 2008, p. 70)

CONCLUSION

In the caring professions there needs to be
a space for caring …

a space that allows people to care
and be cared for –
yet provides protection for the disempowered
and for those who could care so much they would need care too
there is a place for behaviour norms and standards

a space that brings forth the best of professionalism
in an ethic of caring
yet balances such caring with other ethics
of equity and doing no wrong
there are reasonable places to “draw a line”

a space that gives what (care) is needed
without squandering personal energies

or limited resources
there is a balance to be achieved

a space where individuals can choose their paths
and work and care with knowing and respect for those we care for
as well as respect for systems
that are trying to do the often impossible with limited resources
there are relationship and working spaces to be negotiated.

NOTE

[i] Quotes are from research participants in the *Caring at End of Life* or *Caring Journeys* research projects.

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11. ACCESS, AGENCY AND ABILITIES

Central to health practice is the aim to use professional knowledge and capabilities *in the service of others* (Higgs, 2012). The inherent humanness of health practice highlights the importance of health practice relationships in shaping individuals' access, agency and abilities for the achievement of meaningful health outcomes. In this chapter we identify critical examination of self (personal values and beliefs), practice tradition (including Western health and medicine) and practice contexts (including treatment beds, stethoscopes, and so on) as fundamental to the establishment of authentic health practice relationships. As you question taken-for-granted aspects of your health practice, we challenge you to make the familiar strange, in order to bridge any gaps that may exist between you as a healthcare provider and those with whom you work on a daily basis. We contend that bridging these gaps is critical to empowering *capability* in individuals and we offer the concept of *assemblages* as one meaningful possibility for enhancing individuals' access, agency and abilities.

ILLUMINATING AUTHENTIC HEALTH PRACTICE RELATIONSHIPS

Authentic health practice relationships are central to achievement of health practice aims in terms of meaningful and valued health outcomes for other people. This chapter purposefully adopts a broad approach to understanding and illuminating multiple dimensions of authentic health practice relationships. We look beyond the use of highly developed communication skills to establish rapport with clients in order to identify shared goals and facilitate compliance with treatment regimes initiated by health practitioners. Instead, we challenge health practitioners to question the often tacit influences on the formation of authentic health practice relationships: influences of health practice contexts, health practice traditions, and individual health practitioners' values and beliefs. We believe that Martha Nussbaum's (2006) three freedoms essential to democratic citizenship provide a salient framework for examination of the manner in which authentic health practice relationships shape access, agency and abilities of those with whom health practitioners work. These three freedoms are the freedom to engage critically with oneself and one's tradition, the freedom to imagine citizenship in both national and world terms, and the freedom to reach out in imagination to gain insight into the experience of another.

Health practice contexts can be viewed as having a pervasive influence on the enactment and formation of health practices, including the formation of relationships underpinning those practices. Professional health practices are always

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situated; they take place in social and political contexts that are geographically and temporally located (Kinsella & Pitman, 2012). Saltmarsh (2009) underlined the significance of environmental influences on health practices with her claim that no clinician can operate independently of the communities and contexts in which the work takes place. Thus, the health practice contexts thought of as a part of health practice need to be problematised; they simply cannot be taken for granted (Green, 2009). Healthcare practitioners currently work in healthcare environments of increasing complexity and rapid change, of fiscal constraints and demands for accountability that also require the establishment of collaborative partnerships with clients, caregivers, peers, colleagues and other health practitioners (Ajjawi & Patton, 2009). Given the centrality of context to the formation of health practice relationships we encourage you to take a moment to consider the manner in which your particular practice environment influences the way you construct meaningful relationships with your clients. Perhaps consider the way your practice environment both enables and reveals power asymmetries in your relationships with your clients.

While contemporary health practices are situated in both practice contexts and practice traditions, they remain fundamentally relational in nature. Health practitioners are required to work collaboratively with colleagues and clients to produce meaningful and valued outcomes for individuals in unique practice contexts. This relational model of health practice highlights an embodied dimension of health practice, with health practitioners themselves constituting an integral part of health practice. To better illustrate the significance of embodied, embedded and contextual factors for development of authentic health practice relationships we provide this scenario. Imagine you are in a hospital bed, semi-reclined, wearing a bloodstained hospital gown, following emergency surgery, when a surgeon you have never met, along with a registrar, intern, and nurse unit manager, comes to speak to you about how your surgery went. The surgeon appears harried and briefly describes the surgery to you, reassures you that all went well and briefly pauses to ask if you have any questions. How do you respond? Do you have time to frame a question? If so, do you have the confidence to ask the question and potentially delay the surgeon? We now invite you to take some time to imagine how your relationship with the surgeon might be different if you are an Indigenous person or a Sudanese refugee, an elderly person or a child, if you have a hearing impairment or an intellectual disability, an alcohol or drug dependency, or if your surgery was the result of a failed suicide attempt. Finally, we challenge readers to examine honestly how your capacity to understand the other and your personal and professional values and beliefs combine to shape the quality of the relationship you would form as a health practitioner with each of these individuals.

In this section we have asserted that authentic health practice relationships require critical understanding of oneself and one's tradition (including practice contexts), as well as the freedom to embrace the lives and stories of others in a respectful and non-judgemental manner. We have encouraged you to commence a journey of critical examination of the values and beliefs underpinning your health practice, and to develop explicit awareness of the influence of health practice contexts on the character of relationships you form with others. We urge you to aspire to the formation of authentic health practice relationships built on a bedrock of reciprocal respect, trust and holistic understanding of other individuals, relationships that honestly seek to empower those with whom you work to achieve outcomes that are valued and meaningful to them.

AUTHENTIC HEALTH PRACTICE RELATIONSHIPS: IN WHOSE INTEREST?

Few people would disagree that authentic, meaningful and respectful interpersonal relationships are a priority in contemporary healthcare. While we rightly place great value on professional skills and our ability to practise efficiently and effectively, it is often the relationships between people that define the quality of a person's experience of healthcare. Given the value of meaningful health practice relationships, it is surprising that so many people are routinely poorly treated by health professionals. A recent UK report showed that every week 3,000 people make formal complaints in the NHS, with the most frequent specific cause for complaint being staff attitudes and poor communication (HSCIC, 2013). Anton Kuzel (2004, pp. 338-339) described it this way;

> You cannot get a human being on the telephone, and you cannot get an appointment. When you do have an appointment, you wait an excessive time before seeing the doctor, who is in a hurry, does not seem to care, and provides inadequate explanation and education … Each event had the potential to weaken the patient's relationship with the clinician and culminate in loss of trust in the health care.

Although we might all agree on the importance of meaningful health practice relationships, we are often at a loss to explain why they are often absent or poorly managed in healthcare. We have touched on some of the possible explanations already; asymmetrical power relationships, the complexity of healthcare and the growing economic pressures on collaborative working, and the situated "otherness" of patients. All are important contextual factors, but we also want to emphasise the need to challenge taken-for-granted assumptions about the function of Western healthcare, to propose that sometimes it works *against* our desire to develop meaningful health practice relationships.

Many authors now argue that the biomedical discourses that underpin Western healthcare privilege the expert clinician over the "lay" knowledge of the patient. The much prized objectivity and value-neutrality evident in modern evidence-based practice creates rather than reduces the distance between client and healthcare provider. The reductionism and Fordist efficiency of modern healthcare create the feeling that one is a part of a very large machine, and that healthcare is about processing "units" rather than dealing with real people (Shilling, 2003).

Although many of you reading this book will be health professionals, we have all at one time or another been consumers of healthcare, and we expect that our beliefs and opinions *should* matter to our healthcare provider – particularly at times when we are at our most vulnerable. Only rarely are we ever required to be passive in the face of severe and debilitating illness. Only rarely do we willingly hand over our bodies to the mercies of a skilled professional and ask for someone to take this excruciating pain away, remove or repair a body part, or prevent death. For most of the rest of the time, we expect to be partners in decisions that are made about us. Yet all too often, it is us, in our "other" role as health professionals and not patients, who allow healthcare exigencies and with attendant ideologies to override our humanistic sensibilities and treat people as if they were merely cogs in an enormous machine.

The tensions that exist between our desire to offer truly meaningful health practice relationships and the realities of modern healthcare have been thoroughly explored in recent years, particularly by those who have traditionally found themselves marginalised by medicine. Extrapolating from broader social moves after World War II, black civil rights campaigners, feminists, queer theorists and disability rights activists argued the need to "give voice" to the disenfranchised. From these movements emerged social models of disability, qualitative health research methods, medical sociology and humanities, and other initiatives that offer critiques of the hegemony of medicine – and its tendency to create distance between doctor and patient – and propose new ways of building meaningful relationships in healthcare practice. We look at one such example in the section below "Bridging us and them".

ACCESS, AGENCY AND ABILITY

Capability as a Way to Achieve Meaningful Outcomes

In this section we take a nuanced approach to understanding who has access, agency and ability in relation to health and who does not. We look beyond the determination of an individual's access to healthcare through the categorisation of individuals into identified groups of disenfranchised people such as those of a lower socioeconomic status, Indigenous peoples, rural people, refugees, homeless, and so on. We do not disagree that these groups (and many more) are in fact disadvantaged in relation to access to health and that identification of disenfranchised groups is important, particularly for apportioning resources to reduce disadvantage. It is our contention, however, that everyone's ability in relation to health is also largely determined by the character of the unique and fluid relationships established between those seeking healthcare and healthcare providers. Through fine-grained examination of the relationships you develop with others, we argue that in your everyday work as a healthcare provider you can enhance individuals' ability to achieve meaningful healthcare outcomes.

To develop this nuanced approach to access, agency and ability we adopt the writings of Indian philosopher Amartya Sen on *capability* and the implicit call for people with power (such as health practitioners) to take responsibility for bringing about changes that would enhance human development in the world (Sen, 1999). Sen described capability in terms of the alternative combinations of valued or desired outcomes people are able to achieve. The positive outcomes people can achieve are influenced by economic opportunities, political liberties, social powers, and the enabling conditions of good health, basic education and encouragement of initiatives. Sen's description of capability encompasses individuals' access, agency and ability to secure meaningful outcomes. Understanding capability in this way helps us to discern whether individuals are able to do the things they value doing, and whether they possess the means or instruments or permissions to pursue what they might like to do. Most importantly, this understanding of capability allows us to examine our own health practitioner practice in terms of whether it enhances or diminishes the capability of those with whom we work on a daily basis.

We now ask you to look beyond ubiquitous understandings of disenfranchised individuals as members of pre-ordained groups, and to use the concept of otherness as a lens to examine more closely how your individual healthcare practice enables or constrains the capability of those with whom you work. In this examination of practice, begin by identifying someone you perceive as different to yourself and about whom you have limited understanding. This will depend on your own background and life experiences. As an example, health practitioners who have undertaken service work with community groups such as Matthew Talbot Soupvans may have developed a deeper understanding and acceptance of people with drug or alcohol dependencies. Also consider how individuals with whom you work may feel reduced by your language, your dress and the physicality of your practice rooms. For example, consider how your power as a healthcare practitioner is reinforced in the way you dress (do you wear a uniform, collar and tie, or white coat?), the language you use (in your language do you implicitly expect compliance with your intervention choices?) and the physicality of your practice rooms (where do you position yourself in relation to your clients during client consultations?). And, we ask you to recognise a fluid and dynamic dimension of capability, in that individuals' capabilities are not fixed and in fact may fluctuate from day-to-day. We contend that individual capability is also influenced by how individuals are feeling on any given day. A person's level of physical and mental wellbeing, amount of pain, recent experience of social exclusion, and family disharmony can decrease an individual's capability to achieve meaningful outcomes at particular points in time.

In this section, we have identified capability as a meaningful construct to assist identification of individuals' level of access, agency and ability in relation to the achievement of meaningful health outcomes. We have argued that individual capability is in large part determined by the character of a unique, fluid and interdependent relationship between individuals seeking healthcare and healthcare providers. Given that health practitioner ethical guidelines are founded on principles of justice and equity, those practitioners are behoven to strive to ensure that everybody has the freedom to achieve health outcomes that are meaningful and important to them. In the following section we imagine possibilities for equal and just healthcare practice.

BRIDGING US AND THEM

Sen's notion of *capability* reminds us that there are many structural factors underpinning the reality of people's health. Poverty, poor education, access to services, a clean environment, and so on all contribute to the incidence and prevalence of communicable and non-communicable diseases (Greenhalgh, 2008). We forget, too easily perhaps, that as health professionals we are also agents of social change, connecting people in need with technologies that can make lives more meaningful. Here, we are referring to technologies as tools to help a person achieve a meaningful life. Technology of this sort could be a home adaptation, an animal or human companion, or a strategy designed to make life more fulfilling.

One of the most exciting innovations in this area comes from the work of Barbara Gibson at the University of Toronto. Gibson's work draws on a range of critical philosophical positions and explores the notion of connectivity and *assemblage* (Gibson, 2006; Gibson et al., 2009). Drawing on the work of Pierre Bourdieu and Gilles Deleuze, Gibson and colleagues have developed the earlier work of Margaret Shildrick to propose a new way of thinking about our engagement – as consumers and providers – with health and illness. Simply put, they propose that we form assemblages with "technologies" to connect with the world and engage in what occupational therapists call "meaningful activities". While this argument has been made elsewhere before, Gibson's critical point of difference is that she argues that assemblages make no distinction based on normative judgements about ability and disability. Thus, there is no distinction between the assemblage made by a blind man and a sighted dog and that made between a shepherd and a sheep dog. Both make use of a productive assemblage to mediate their engagement with the world.

Assemblages are the connections that form between all objects, animate or inanimate, organic or inorganic, and are always greater than the sum of their individual parts. So, as explained by Manuel de Landa (2006), a group of objects that aggregate together without enhancing each other is merely a collection, but an assemblage amplifies each individual entity and offers new possibilities. For instance, oxygen and hydrogen separately can fuel a fire, but combined together they can put it out.

In your own life, think of the assemblages that you form with technologies to make possible things that otherwise would be difficult. The chair you are sitting on perhaps, your reading glasses, or the colleague who lent you this book to read. We all use technologies to engage meaningfully in the world. In health, one of the most significant assemblages is formed between clinician and patient, and in this section we have argued that there are many structural factors that obstruct our ability to nurture these assemblages. Framing our meaningful relationships in this way, however, allows us to offer a radical critique of both a medical and social way of viewing the world and to offer some tantalising possibilities for re-imagining the study of health practice relationships. Rather than envisioning a knowing expert dispensing knowledge to a passive patient, or conversely, an emancipated lay person struggling to try to claim a foothold in a monolithic health system, we now have a field in which we can recognise that each of us is dependent on various assemblages to mediate our being-in-the-world; the doctor and his stethoscope as much as the “enwheeled”' child and the powered chair (Papadimitriou 2008); the therapist, client and treatment bed (Nicholls, 2012), and the person using a care worker to help with toileting. The challenge is now to explore what might be gained and what might be lost by our appreciation for assemblages as a new mode of expression in health professional relationships.

CONCLUSION

In this chapter we have challenged health practitioners to heed Sen’s (1999) call to contribute to the building of a more just society, with human dignity and wellbeing for all, through the establishment of authentic health relationships with others. The criticality of these relationships was highlighted in our contention that the character of the unique and fluid relationships established between individuals seeking healthcare and healthcare providers largely determines individuals’ ability in relation to health at any given time. We identified the concept of *capability* as a useful way to explore people’s level of access, agency and ability in relation to the achievement of meaningful health outcomes. We also highlighted the manner in which the formation of these relationships is shaped both by the complexity of contemporary health contexts and by individual practitioners’ values and beliefs. Finally, we proposed that consideration of the construct of *assemblages* provides a useful way forward in the development of authentic health practice relationships and consequent empowerment of individuals’ access, agency and ability in relation to healthcare.

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12. EXPECTATIONS AND RESPONSIBILITIES

EXPECTATIONS AND SERVICE QUALITY

It is increasingly recognised that expectations are integral in determining the quality of health services, because expectations strongly affect people's experiences of health services (AIHW, 2012, p. 32). The New South Wales Ombudsman is an independent body charged with watching over public sector and many private sector organisations and their staff to make sure that they "do their jobs properly and meet their responsibilities to the community" (NSW Ombudsman, 2014). This body offers a simple formula for calculating satisfaction with services (NSW Ombudsman, 2012, p. 1):

satisfaction = (quality of service) – (expectations)

The NSW Ombudsman notes that "consumers will only be satisfied with a quality of service that is equal to or exceeds their expectations. Quality service therefore comes from continuously improving the service and knowing and managing the expectations of your consumers" (NSW Ombudsman, 2012, p. 1).

How often has a health practitioner clarified what you can expect from them or asked about your expectations? If you are a health practitioner, what strategies do you use to ensure that your expectations align with those of the people you are serving? While it may seem obvious that people's expectations are related to their satisfaction with services, research findings reveal that understanding and working with expectations is complex, with expectations affecting health practices and outcomes in multiple ways.

In their comprehensive literature review and study of expectations of people using general practices and hospitals in the UK, Bowling et al. (2012) highlighted that not only do expectations influence satisfaction with services, but they also affect recovery. Expectations have been found to influence health behaviours in older adults (Meisner & Baker, 2013), the ways families choose interventions for hearing impaired children (Oshima, Suchert, Blevins, & Heller, 2010), family-centred health services in Ireland (Coyne, 2013) and young people's engagement and outcomes in mental health services (Watsford, Rickwood, & Vanags, 2013). Clearly, understanding and clarifying expectations should be an important focus for health practitioners and health services.

J. Higgs et al. (Eds.), Health Practice Relationships, 101–108.

EXPECTATIONS AND RESPONSIBILITIES – THE IMPORTANCE OF CONTEXT

As populations become more diverse so do public expectations of health systems (AIHW, 2012). "Expectations are shaped by the experiences of each individual, which are in turn shaped by such things as age, gender, locality and cultural background" (AIHW, 2012, p. 17). In this landscape of increasing diversity, if we are to understand and engage with expectations, we need to take the context of the individual and the service into account.

Context has become so important in how we understand health that it is included in definitions of health and disability, and in tools for assessing the health of individuals as well as the performance of practitioners and health services. Since 2001, the World Health Organization's (WHO, 2014a) International Classification of Functioning, Disability and Health (ICF), which measures health and disability, has included contextual factors such as participation restriction and activity in the definition of health and disability. Assessing the health and disability levels of individuals and populations as well as the quality of health service delivery now includes, in addition to body structure and function, six domains of "cognition, mobility, self-care, getting along, life activities and participation" (WHO, 2014b). The role of environment or context in causing ill health and restricting people's ability to participate is much better recognised. The responsibility for "recovery" has also shifted.

Instead of health and disability being seen as solely located in "sick" individuals who are expected to do all they can to follow the instructions of expert medical staff (usually doctors) to regain full health and return to a "normal" state of being fully able-bodied, it is now understood that environmental barriers to participation and functioning (both physical and attitudes/expectations) are just as important. The sociopolitical model of health and disability (Smart & Smart, 2012), which views disability as an issue of rights and, among other things, calls for people in the "patient" role to be included in decision making about their treatment as equal citizens rather than passive collections of symptoms with no voice, is the name given to the newest model or paradigm for understanding disability. Practising within this model creates very different expectations from those within the traditional biomedical model.

A case from one of the authors' practice illustrates how these different expectations can affect interventions. Tim is a young man with a deteriorating neurological condition who has marked tremors that affect gross motor and fine motor coordination and who uses a wheelchair full time. He enrols in a residential rehabilitation setting, with the stated aim of learning to "live independently", working with a range of health practitioners. One day, while preparing his dinner under the supervision of residential staff, he spills a packet of frozen peas onto the floor of his kitchen. Despite the instructions of the staff he refuses to pick up the peas. The next day the social worker and occupational therapist are called. He still refuses to pick up the peas. The stand-off between Tim and the staff continues for some days. Now that Tim is labelled a "behaviour problem", the psychologist is asked to intervene. Following a lengthy consultation with Tim, she calls a staff meeting. “Do you realise how humiliating it is, and how long it would take, for this young man to have to crawl around and pick up these peas?” she asks. “It is more efficient and appropriate for a person with the physical capacity to pick them up, to be asked to do so”. The gathered staff look at each other. We realise that we have fallen into the biomedical model – which sees the solution to impairment as modifying the behaviour of the individual to more closely approximate that of an “able-bodied” ideal, rather than stay with our professed sociopolitical model – which sees independence as the ability to make the decisions and organise the support needed to live independently, rather than having the physical capacity to perform specific tasks.

This absurd but real-life example illustrates the power of the biomedical model to influence health practitioners’ expectations and behaviour, even in situations where the rhetoric of the sociopolitical model is articulated. Despite ongoing calls for its inclusion in health professionals’ practice, e.g. in nursing (Scullion, 2010), in social work (Beaulaurier & Taylor, 2012) and in counselling (Smart & Smart, 2012), the expectations of the biomedical model continue inappropriately to dominate many of the interactions between health practitioners and people who use health services.

HEALTH CONSUMER EXPECTATIONS

An important aspect of context, which is not always taken into account but which strongly influences expectations, is the level of emotional, behavioural and cognitive functioning of the person seeking a health service. Often people needing health services are in crisis – a technical term used by health practitioners to mean that a person is overwhelmed by a situation such that their usual coping mechanisms no longer work. James and Gilliland (2005) pointed out that people presenting to a service in crisis vary along a continuum of decision-making capacity. At one end of the continuum the person is totally immobilised by the crisis, requiring health practitioners to “take over” for a time and make direct interventions for the good of the person. Around the middle of the continuum the person is partially mobile and the practitioner works collaboratively with the person. At the other end of the continuum, the person requiring a health service is fully mobile. In this situation the health practitioner offers information and options, and the person is fully in charge of the decisions affecting his or her life. These authors argue that health practitioners need to constantly assess people’s emotional, behavioural and cognitive mobility and adjust their expectations and behaviour accordingly. Mirroring this, the expectations of the person seeking health service will vary according to their position on this continuum at any point in time.

With the rise of the sociopolitical model, also known as the “consumer rights movement”, introduced in the previous section, and with increasing recognition of the importance of expectations in assessing the quality of healthcare and health outcomes, general standards of expectations of people who use health and other services have been enshrined in legislation and policy in most First World nations.

To implement these policies, organisations have been established to deal with the complaints that arise when expectations are not met.

The NSW Ombudsman (2012, p. 1), quoted in the introduction to this chapter, lists five key dimensions of consumers' expectations of services. While taking care to clarify that this does not mean that services should always give consumers what they want, the Ombudsman argues that if services perform well on these five dimensions of consumer expectations they will maximise consumer satisfaction with services. The five dimensions are:

- The physical appearance of offices, staff and communications (termed tangibles)
- The ability to perform the promised service dependably and accurately (reliability)
- Knowledge, courtesy and credibility of staff and ability to convey trust and confidence (assurance)
- Willingness to help and provide prompt service (responsiveness)
- Willingness to provide caring, individualised attention (empathy).

The Ombudsman summarises worldwide research findings about what consumers expect from government services. According to the Ombudsman it is important to address these expectations, not only because many consumers have a sense of entitlement due to being taxpayers, but also because many other consumers have no choice or power about accessing these government services – they use these services because there is nowhere else they can go. Worldwide research findings about consumer expectations of government services are summarised as:

> People want to be treated like they are valued.
> They expect courtesy, respect, impartiality and honesty.
> They want processes that are easy to understand.
> They want timely and reliable advice and service and they don't want to be given the run-around.
> They want options for where and how the service is provided.
> They want clear advice in letters, forms, publications and verbal communications.
> They want fair and friendly treatment.
>
> NSW Ombudsman, 2012, p. 1

In 2008, Australian Health Ministers endorsed the *Australian Charter of Healthcare Rights* for use across the country (Australian Commission on Safety and Quality in Health Care, 2008). Other First World nations have similar charters. Echoing the more general consumer expectations summarised by the NSW Ombudsman, the *Australian Charter of Healthcare Rights* outlines seven key rights that apply to consumers, practitioners and healthcare organisations alike. These include access, respect, safety, communication, participation, privacy and comment (the right to complain about care and to have concerns dealt with properly and promptly).

While the rhetoric about meeting consumer expectations becomes ever more explicit, there is clearly huge variation in consumer expectations and whether they are met, as seen, for example, in the increasing diversity in expectations noted by the Australian Institute of Health and Welfare (AIHW, 2012). Two stories from the authors' recent experiences illustrate this variation. The mother of one of the authors was recently hospitalised for major surgery in another state. The night of the surgery this author was pleasantly surprised to receive a long and detailed phone call from the surgeon, explaining the outcome of the surgery and what could be expected post-operatively. Her expectations about healthcare were far exceeded. In contrast, the other author visited a colleague in hospital who had undergone a complicated hip replacement. During a ward round by a young registrar, the colleague was so offended at the registrar's attitude towards her that she exclaimed, "You arrogant little *** … just get out", which he did. In following ward rounds later in the week the woman explained to the registrar that she was a human being as was he, and that she expected to be treated with respect when he was talking to his students in her presence. Throughout the next week this woman received visits from young doctors thanking her for her intervention and for saying what they could not. The registrar has since been charming to this woman, but she wonders how he behaves with people who are not prepared to stand up for themselves.

HEALTH PRACTITONER AND ORGANISATIONAL EXPECTATIONS

As demonstrated in the examples above, health practitioner and organisational expectations are important because they powerfully shape health outcomes and experiences for health service users as well as expectations of the community more generally and of students or trainees more specifically. Berry, Gerry, Hayward, and Chandler (2010) provided a salient example of how health practitioners' low expectations and stigmatising views of health service users actively contribute to poor health outcomes and experiences. These authors found that pessimism about prognosis and attribution of negative characteristics to mental health service users were common among mental health practitioners. This in turn can lead practitioners to underestimate the ability of service users to be involved in decisions regarding their own care and medication, which could manifest as lack of collaboration between practitioner and service user. Moreover, these low expectations could be inadvertently conveyed to the general public (e.g. in interactions with carers, the media and personal acquaintances) and to students or trainees whom they teach or supervise. This inadvertent conveyance of low expectations or stigma is of particular concern as it perpetuates the conditions for poor health outcomes and experiences for service users. Health practitioners are therefore strongly encouraged to examine their individual values and beliefs in regard to those individuals with whom they work, to reveal the way in which those beliefs both shape their practice and are tacitly passed on to neophyte practitioners and the general community.

There is growing recognition that the emerging health practitioner workforce has very different professional expectations from those of earlier generations (Gallagher, Clarke, Eaton, & Wilson, 2007). For example, a group of vocational dental practitioners in the UK chose dentistry because they perceived dentistry as a financially lucrative, contained career in healthcare, with professional status, job security and the opportunity to work flexibly (Gallagher, Clarke, Eaton, & Wilson, 2007). This vision of a favourable work/life balance is in stark contrast to the view of Hanlon, Halseth, and Ostry (2011) of "stealth volunteerism", those acts of volunteerism undertaken by professionals over and above their formal responsibilities. Hanlon et al. used that term in recognition of the fact that the activities themselves are not easily identifiable, and also because the underlying systemic conditions that create the need for this type of volunteerism are often masked behind personal and professional commitments to help. Such volunteerism is more common in rural contexts where healthcare access is typically restricted and health practitioner workloads are consequently very high. Examples of stealth volunteerism include assisting support groups and helping clients and their caregivers to navigate health and social care systems. Significantly, Hanlon et al. found that these extraordinary efforts were not rewarded or acknowledged in any official sense and came at significant personal and professional cost to health practitioners. Continued acts of volunteerism place health practitioners at greater risk of burnout from role overload. These two examples highlight significant differences in health practitioners' expectations of their role and commitment to achieving positive health outcomes for health service users. From these two examples it may be inferred that younger generation health practitioners may be more focused on a positive work/life balance and therefore may be less susceptible to the burnout inherent in the undertaking of stealth volunteerism activities than their older colleagues. If this is indeed the case it raises a critical question for the future provision of quality healthcare: How will healthcare organisations bridge the gap between organisational provision of services and healthcare users' service needs?

Organisational expectations strongly shape health practitioners' practice and consequently the health experiences and outcomes of health service users. Organisational expectations are broadly visible in the organisational culture (vision and mission statements as well as staff attitudes and behaviours), practice models (e.g. adherence to treatment protocols and pathways) and articulation of goals and outcomes. Dubois et al. (2013) demonstrated that four distinct unit-level nursing care organisational models, characterised by contrasting staffing, professional practice environment and innovation characteristics, were associated with different levels of risk of adverse outcomes for patients. Their findings highlight the significant influence of organisational expectations viewed as practice models on healthcare practice and consequently on health outcomes. The setting of health service targets and reporting requirements against achievement of those targets reveals what is most valued at an organisational level. For example, an organisational focus on reporting of occasions of service and patient turnaround times reveals privileging of efficiency over quality of care and perhaps service user experiences. This privileging of efficiency may create a tension between organisational expectations and health practitioners' moral or professional responsibility to provide the best treatment for individuals in given circumstances.

Strategies for balancing expectations and responsibilities should start at the very beginning, that is, with the ethos and values of the practitioners and the service for which they work. It is important that health practitioners become aware of their own values, beliefs and practices (the models or paradigms within which they operate) as well as those of the organisations within which they work and the professions they represent, so that cultures, attitudes and beliefs that are not inclusive of health service users' expectations, values and beliefs are identified and eradicated. In this way, more inclusive cultures can be constructed that nurture the wellbeing of all stakeholders.

CONCLUSION

While documents such as the *Australian Charter of Healthcare Rights* take great care to align consumer, practitioner and healthcare organisation expectations and responsibilities, such efforts will remain at the level of empty rhetoric unless they are known about and practised by the three groups of people they are meant to assist: people who use health services, healthcare practitioners, and the organisations that deliver healthcare. Thorough understanding of health user expectations, combined with understanding of how organisational and professional expectations shape practice, will empower individual health practitioners to construct effective and enjoyable health practice experiences with and for health service users to achieve meaningful health outcomes.

This chapter began with the provocative formula proposed by the NSW Ombudsman, revealing that satisfaction with services, quality of service and expectations are closely related. The first step in working with people's expectations is to understand your own. Once practitioners clarify which models they work within, including their own values, perspectives and philosophies of healthcare, they will be much better prepared to ask the people who use their health services what they in turn expect. Similarly, people using health services will be better prepared if they can articulate their expectations to health practitioners. In this way, realistic partnerships will develop that can lead to improved health and higher quality health services for everyone.

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SECTION 3: HEALTH PRACTICE RELATIONSHIPS NARRATIVES

TRACY LEVETT-JONES

13. PERSON-CENTRED CARE (IN NURSING)

Seek First to Understand and Then to Be Understood …

Person-centred care[1] (PCC) is a holistic approach to the planning and delivery of healthcare that is grounded in a philosophy of personhood. While there are many definitions of PCC in the literature, each promotes self-determination and a commitment to helping individuals lead the life they want. Health professionals who practise in a person-centred way acknowledge that each person is unique, has equal rights and worth, and brings experiences, skills and knowledge about their health and illness. Person-centred nurses are typically empathic, respectful, ethical, open-minded and self-aware. They tend to have a profound sense of personal responsibility for actions (moral agency), they place the "person" at the centre of healthcare, and consider the person's needs and wishes as paramount.

In this chapter I explore the rationale for and benefits of practising in a person-centred way. Narratives highlighting both positive and negative examples of PCC provide opportunities to reflect on and examine the attributes, meaning and relevance of PCC to clinical practice. The chapter concludes with a discussion of the relationship between PCC and patient safety.

SETTING THE SCENE

Contemporary healthcare is complex and challenging. Consequently nurses sometimes contend that PCC is not possible because of time constraints and competing clinical demands. Although these nurses may espouse the importance of PCC, their practice tends to be profession-centric, focusing on procedures and routines that can disregard individuals' needs, experiences, views and treatment preferences. Nurses who work from this paradigm fail to consider the impact of PCC on patients' experiences, staff satisfaction and the culture of the healthcare organisation.

There is clear evidence that clinical cultures that support PCC are beneficial to patients and to staff. However, to be person-centred requires genuine therapeutic presence and a capacity and willingness to bring one's whole self into the patient interaction (Geller, Greenberg, & Watson, 2012). Once you are fully present, you are then in a position to communicate in a way that is therapeutic to the patient (Rossiter, Scott, & Walton, 2013) and PCC becomes not just a concept but a reality.

In the following section three narratives are presented. Each is drawn from either my experience or that of a colleague. The narratives are concerned with description, meaning, understanding and interpretation. They provide a framework that captures the phenomenon of PCC in a way that may be only partially conveyed by other descriptive writing methods. There is juxtaposition of the narratives, with the first depicting a

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negative image of PCC, the second a more positive (although not perfect) illustration, and the third exemplifying a person-centred relationship between colleagues. Each narrative provides greater clarity and insight into the meaning of the others.

MRS ALI'S STORY

Mrs Ali, a 97-year old woman, was admitted from a residential aged care facility to the medical ward of a small rural hospital. She had a history of bleeding duodenal ulcers and this was her third admission in 3 months for melaena and haematemesis. Mrs Ali's previous admission had been three weeks earlier. She was managed by the local general practitioner and her treatment regime was conservative as she had multiple serious co-morbidities. Mrs Ali's haemoglobin (Hb) was 88g/L. She was ordered a blood transfusion of one unit of packed cells. Mrs Ali was adamant that she did not want the transfusion, and despite having it explained to her in detail, she refused to consent to it.

The nursing staff notes indicated that at times Mrs Ali seemed slightly confused. For example, she accused people of stealing her purse, but it was subsequently found in her drawer, and from time to time she asked if her dog "Barney" had been fed (although, as it turned out, Barney had died many years before). The new graduate registered nurse on duty felt uncomfortable about acting against Mrs Warren's express wishes. Living in the same community, she knew Mrs Ali and her family well, and had also cared for her during previous admissions. However, she was reluctant to speak up and challenge the more senior nurse on duty. The registered nurse (RN) in charge of the ward had recently moved to the town. She decided to contact Mrs Ali's estranged son and he gave consent for the transfusion. The RN then spoke to Mrs Ali. She began the conversation, "Sweetheart, I understand that you don't want this transfusion but the doctor has ordered it. Your son has consented and we really need to get on with it. We'll pick up the blood and get things started in a few minutes, OK". Mrs Ali nodded then turned her head away.

Reflection

While person-centred care is evidenced by a positive, facilitative and open partnership between nurses, patients and families, negative behaviours and interactional styles can lead to physical and psychological deterioration, too often creating a spiralling effect that leads to diminished self-esteem, withdrawal, frustration and even anger (Institute for Patient- and Family-Centered Care, 2011). In reflecting on Mrs Ali's story, consider the behaviours that facilitate PCC and those that undermine this approach, as listed in Table 13.1.

Far from being person-centred, Mrs Ali's nurses ignored her wishes and excluded her from making decisions about her healthcare. As such, Mrs Ali was disempowered and treatment was provided without regard to her beliefs or psychological wellbeing. This is not to say that the health professionals responsible for Mrs Ali were not well intentioned. Indeed, the narrative indicates that the nurses were convinced that a blood transfusion was the best, if not the only safe treatment option for Mrs Ali. However, the nurses' behaviours and interpersonal interactions demonstrate a patronising and paternalistic approach. The language used to convince Mrs Ali to comply with the ordered treatment ("Sweetheart, we really need to get on with it") was both patronising and ageist and the RN's approach was dismissive and demeaning.

Table 13.1 Behaviours that facilitate and undermine person-centred care

Positive behaviours that facilitate person-centred care	**Negative behaviours that undermine person-centred care**
Appreciate that each person has a unique life history that influences their healthcare experience.	Treat patients as no more than episodes of care, a procedure or a diagnosis; e.g. I have three feeds or I have a bowel resection coming back from theatre.
Inform and involve patients in their care; seek to understand their perspective and elicit their preferences.	Disempower patients by ignoring their wishes or excluding them from healthcare decisions. Provide care without regard to the person's wellbeing and as if they are not a sentient being.
Promote active involvement of family and friends.	Ignore or overlook the views and concerns of significant others.
Respect patients' culture, values and personal beliefs; be sensitive to non-medical and spiritual dimensions of care.	Disregard patient's belief and values. Fail to validate the person's experiences, feelings, values and beliefs.
Maintain patient's dignity through communication interactions, language, tone of voice and behaviour.	Damaging the self-worth of an individual through patronising, disparaging, dismissive or demeaning comments, language or behaviours.
Design care processes to suit patients' needs, not providers' needs.	Provide task-oriented and routinised care.
Be transparent and provide access to health information.	Withhold information or deliberately deceive people about their condition, options or treatments.

It would seem that Mrs Ali’s occasional episodes of confusion caused the nurses to question her decision-making capacity. Contacting her son for consent for the transfusion, even though he and his mother were estranged, undermined Mrs Ali’s dignity and self-determination (as well as being illegal). Too often, the personhood of people with cognitive changes is disregarded; they are ignored or overlooked; decisions are made about and for them with little consultation. A person-centred approach facilitates shared decision making by acknowledging each individual’s rights, choices, values, and potential.

This narrative also demonstrates that speaking out in favour of PCC can be challenging, particularly within the hierarchies that comprise contemporary healthcare. The new graduate nurse, although apparently familiar with Mrs Ali’s social history, did not advocate on her behalf; had she done so the outcome might have been different. Neither the new graduate nurse nor the more senior nurse sought to understand the nature of or reason for Mrs Ali’s resistance to having the transfusion. Neither did they explain her options and the possible consequences of her decisions. In the narrative the key attributes of PCC – that is, therapeutic presence, upholding of patient dignity, autonomy, choice and trust – were not evident. Contrast this with the next narrative and once again explore the extent to which PCC is or is not evident.

THE STORY OF THE “ILLUSTRATED MAN”

One morning a 3-year-old boy went to the publican in the hotel where he was staying with his father, saying that he could not wake his daddy up. The man, in his thirties, had taken an overdose of antidepressants and had injected methadone; he wanted to die. An ambulance was called and he was taken to hospital.

The man was in hospital for several weeks. At first the nurses knew very little about him. He was in intensive care and intubated, so could not speak. Many of the staff caring for him were critical about what he had done. Their opinion of him worsened further when they found out that he had recently been in jail. His appearance also alienated them – he had piercings and tattoos over all of his body. The nurse who recounted this story (who we’ll refer to as Jane), called him “the illustrated man”.

The man needed a great deal of care as he had several medical problems. During his period of hospitalisation Jane heard staff members repeatedly make judgemental comments about the man. She felt angry and distressed that they were so critical of him without knowing his background. Jane began to get to know the man’s family and they told her about his sad and abusive childhood; they explained that he was taking methadone to overcome an addiction to prescription medicine that developed after a serious injury. When the time came for the man to be extubated Jane stayed with him, holding his hand and calmly explaining where he was and what had happened. She thought he might become aggressive or delirious and this was a way to avoid having him restrained or sedated. Eventually the man was discharged to a drug and alcohol rehabilitation centre. By then, and as a result of Jane’s advocacy and commitment, the other staff had grown to know and care for him. He left the hospital, his self-worth and dignity intact, and with a sense of optimism about the future.

When later recounting this story Jane explained that she had always been concerned about the way attitudes and labelling can affect patient care. She felt that because she had helped to make the man more “real” to the staff they were able to be more compassionate and person-centred in their approach and as a result the man’s personhood was safeguarded.

Reflection

This narrative demonstrates the very real impact of PCC. It highlights how an appreciation of a person’s unique life history can be a catalyst for change and for improving the quality of healthcare provision. In this narrative the attributes of PCC are made explicit: seeking to understand the person’s life experiences, demonstrating empathy, active involvement of family and friends, care processes designed to suit the patient’s needs, and sensitivity to non-medical aspects of care, together created a supportive environment that not only facilitated physical healing but also created the potential for spiritual and psychological growth. This reflection would not be complete without acknowledging the actions of the nurse. Her compassion, unbiased, non-judgemental stance and commitment to her patient’s wellbeing are powerful reminders of the potential impact that health professionals can make to the lives of the people in their care.

A PERSON-CENTRED APPROACH TO COLLEGIAL RELATIONSHIPS

This chapter focuses primarily on the people who are the recipients of nursing care, but it is important to remember that PCC also extends also to those we work with and teach. We are all different; each person comes to work or study with unique personal circumstances, expectations, experiences, hopes, concerns and abilities. Personal situations can at times influence professional behaviours – for example, family issues, illness, tiredness and financial pressures can negatively impact how people engage with others in a professional capacity. When a person-centred culture is evident, a colleague or student who is unexpectedly “withdrawn”, “difficult” or “disruptive” may be viewed more compassionately and efforts can be made to understand and support them. Similarly, through self-awareness and refection, our own “difficult” or “disruptive” behaviours can be examined, not just in isolation, but also in relation to how they affect the team culture and functioning.

The final narrative in this chapter illustrates the impact of a person-centred approach to mentoring and supporting nursing students undertaking a clinical placement. In this narrative Ann, a third year nursing student, recalls how a relationship founded on mutual trust and respect promoted her learning and enhanced her confidence.

If You Get a Good Mentor … You Know You're Set

If you get a good mentor, you know you're set. That connection is the key to fitting into the ward and one person can make all the difference. On my last placement I was with the same mentor for almost 2 weeks. That made a huge difference. She knew where I was at; she knew what I wanted to get out of the placement because we discussed it. I felt confident in that placement because we'd had that time of getting to know each other. She'd asked me what experience I had and I knew where she'd come from. Not just work stuff, but I knew that she had family, I knew that she'd been nursing for many years. I knew exactly where she'd come from in a lot of respects, because we'd chatted as we'd worked, and come to know each other quite well. We both knew each other's general attitudes to the work we were doing. We didn't always have similar attitudes but we could see each other's points of view because we'd been able to chat around it, and I think, in a lot of ways we had a very similar outlook. Just because we don't necessarily agree with everything that somebody else tells us doesn't mean that it's not valid either. So we both had that sort of point of view where we're quite open to other people's opinions, without necessarily having to agree with them.

Reflection

A mentor who demonstrates a person-centred approach can be pivotal to students' success; in Ann's words, "one person can make all the difference". Closely linked to person-centred care is the concept of mutuality, that is, the experience of shared visions, goals, characteristics or values, including shared acceptance of differences. In this narrative there was a shared understanding between Ann and her mentor and an appreciation of each other's life story. As a result, Ann felt empowered and enabled by the liberating relationship developed with her mentor and capable and confident in taking control of her learning. In the messiness and complexity of contemporary clinical environments, it is crucial that students experience acceptance and a sense of belonging. This narrative is an example of the impact of person-centred collegial relationships between students and staff.

PERSON-CENTRED CARE AND PATIENT SAFETY

A growing appreciation of PCC and its impact on patient safety is changing the landscape of contemporary healthcare and health professional education. The outdated view of patients as passive recipients of care has given way to one where patients are seen as active participants and partners in healthcare. Patients (and their families) are now seen to have a valuable perspective and a vested interest in ensuring safe care.

PCC and therapeutic communication have been demonstrated to contribute to positive clinical outcomes for patients experiencing chronic physical illnesses and to increase patient satisfaction and adherence to treatment (Levinson, Lesser, & Epstein, 2010). There is a growing evidence base for the benefits of PCC, not only for patients but also for health professionals and healthcare organisations. Research attests to the fact that when health professionals, patients and families work in partnership, the quality and safety of healthcare rise, costs decrease, and provider and patient satisfaction increase (Levett-Jones et al., 2014). When PCC is evident and integrated throughout the system there is a decrease in medical errors, readmission rates, infection rates and mortality rates, and a shorter average length of stay (Meterko, Wright, Lin, Lowy, & Cleary, 2010; Institute for Patient- and Family-Centered Care, 2008). In the care of patients with chronic conditions, studies also indicate that PCC reduces anxiety and improves quality of life (Bauman, Fardy, & Harris, 2003).

Factors such as stress, fatigue, burnout, lack of self-care, overwork, unresolved personal issues, and excessive busyness are likely to reduce an individual practitioner's capacity to be therapeutic and person-centred (Rossiter, Scott, & Walton, 2014; Geller & Greenberg, 2012). Too often, nurses and other health professionals view PCC as another "task" to accomplish on top of an already burdensome workload. Indeed, PCC is not simply a task but an ethos, a way of practising, and a contemporary healthcare imperative.

CONCLUSION

Nurses and other health professionals need to respond to patients' various health issues, vulnerabilities, personalities and situations in ways that are both person-centred and therapeutic. What we say and how we communicate have a significant and often long-lasting impact on the recipients of care. When communicating in a person-centred way, showing genuine respect and gaining trust are essential. Just as important is the recognition of our inevitable personal judgements and biases. PCC is a holistic approach to healthcare that helps and supports individuals to lead the life they want. It has a positive impact on patient safety, patient satisfaction, the quality of team functioning and interprofessional relationships.

NOTE

[i] The terms person-centred, patient-centred and client-centred are often used interchangeably. They are conceptually similar and emphasise the central roles of the person who is the recipient of care and that person's family. In this chapter I use the term *person-centred care* as it is the term most commonly used in the nursing literature and it is inclusive of both patients and colleagues.

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14. DEVELOPING PROFESSIONAL RELATIONSHIPS WITH CLIENTS' FAMILIES

Mothers of Children with Disabilities

Families who have children with intellectual disabilities spend a great deal of their time in contact with health professionals. Their children may be at risk of, or experience, chronic or complex physical and mental health issues related to their disability. Due to the demands of caring, parents can also experience a range of physical and mental health issues that may be neglected. They are often confronted with a system that is hard to navigate, a lack of recognition and respect, inaccessible information and educational resources, with limited services when the challenges become too great. This chapter offers health professionals insight into the journey that families undertake and a guide to future interactions with families.

SETTING THE SCENE

In Australia, 18.5% (4 million) of the population has a disability and in 70% of situations the primary carer is female (Australian Bureau of Statistics, 2013). Today, 99% of families care for their children with disabilities within the home. Mothers represent the vast majority (92%) of co-resident primary carers of children aged 0-14 years with a disability.

Primary carers of children with intellectual and developmental disabilities experience changes in their physical and emotional wellbeing. The child's level of core activity limitation is directly proportional to the level of adverse effects on carers' wellbeing. The more profound the impairment the higher the adverse effects on carers' wellbeing. For example, 47% of primary carers of a child with a profound impairment compared to 31% with a severe impairment reported feeling weary with a lack of energy (Australian Human Rights Commission, 2013). The children are also known to experience a range of chronic and complex health issues that require ongoing monitoring and care. Examples include epilepsy, gastro-oesophageal reflux, dysphagia, constipation or contractures (Tadema & Vlaskamp, 2009). Unfortunately, these families' vulnerability to health issues due to the burden of care and subsequent psychological, social and economic sequelae are exacerbated by their invisibility as a consequence of the disproportionate emphasis on health in individuals with acute conditions (Foster & Fleming, 2008, p. 49).

This chapter presents the views of 13 mothers who had children with a range of disabilities and who were interviewed as part of the author's doctoral research exploring their perceptions of the key health issues they faced. The women, aged between 28 and 78 years, not only had experience as mothers but also had insight

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into the health issues of other families across different socioeconomic groups and life stages. The informants included five service providers from professional backgrounds in disability services, psychology, community services, social work and management. Pseudonyms are used for all participants to protect their privacy.

Themes emerging from the data included unrelenting demands, isolation, loneliness and aloneness; invisibility; being time poor; and "build up to a crisis"– all within the context of overwhelming physical and mental health needs. These themes and narratives are integrated into the discussion below, with emphasis on the relationships that health professionals form with families and the priority areas recognised in the National Carer Strategy (Australian Government Department of Social Services, 2011, p. 13) of recognition and respect, information and education, and services for carers.

RECOGNITION AND RESPECT: *WE'RE ALWAYS THERE*

Health professionals meet families in a range of environments including the family home, but regardless of venue it is important to privilege the establishment of rapport with parents or carers of children with a disability. Carers deserve to be recognised and respected, to feel valued, but unfortunately the reverse frequently occurs where they feel "invisible" and "dismissed" (Australian Government Department of Social Services, 2011). Family members have expertise that they bring to their role as a parent. In contrast, as health professionals we "*do not know what we do not know*!" Recognising family members' strengths and demonstrating empathy with an open mind and willingness to work in partnership demonstrates respect for the person and that person's situation and importantly provides the opportunity to "*learn more about what we do not know*".

The circumstances of many of the families involved in this study were complex. They had 48 children between them, 18 of whom had disabilities and were aged between 2 and 40 years. Six families had one child each with autism, and two families had two children with autism. Five families had children with Down syndrome and associated health issues. Gail talked about life with her daughter who had autism with episodes of behaviour that challenged the family for lengthy periods of time. In her reflection on working with professionals Gail highlighted the often temporary nature of professionals' contributions.

> I must admit I do quite enjoy being involved in this great circus that we live in and I really think it's a circus, because nothing is consistent. You've got different players and actors at you all the time, you've got no one that you're talking to that's in a permanent position and you're the only person that virtually doesn't change. You're always there, you always turn up, always. We're always there, we arrive at every show, every act, we're there, we never let the show down. (Gail, parent)

Although the professionals who were interviewed had worked with families over extended periods, this was not always the case. Families spoke of new graduates working with their child for a year at a time or less. Jane (a parent) found it very difficult to cope with continually changing relationships, with 18 different therapists working with her child over two and a half years. In stark contrast to these temporary relationships, families have their child for life. There is so much involved, the unrelenting demands of caring impacted on the mothers and families. For example, the mothers had to attend various appointments related to early intervention; tests and check-ups with medical practitioners and meetings at schools and disability agencies. As a consequence, Jane reported no spontaneity in life for herself and her partner, who felt that the planning required around managing the numerous appointments impacted on their relationship. The inability to just relax and enjoy life was at times difficult, with Jane stating:

> Can't explain the "ever vigilance", we stop our lives to do whatever it is that we are doing, however vigilance is the constant in our life. What if I was to die? (Jane)

Although not all families experience such challenging circumstances, health professionals can learn much from families and gain great satisfaction from the achievement of positive outcomes. The families wanted to feel respected and to work with health professionals who did not judge them. When family members felt stressed and under continuous pressure they needed to talk, to put the situation into perspective. Initially you, as a professional, may feel that you have to have the answers, or may be scared because you do not know what to say, yet the greatest gift is that of the "*listening ear*".

When a person appears really distressed, sit down (maybe over a cup of tea), ensure that a box of tissues is close and let the person talk and cry (it is often needed). People want to know you are listening and hearing what they are saying without interrupting or offering false hope. Parents may appreciate meeting other families experiencing a similar situation who can empathise with them. This highlights the critical contribution of meaningful health practice relationships to achieving positive health outcomes for families caring for children with disabilities.

REFLECTIVE QUESTIONS

For health professionals:

- Do you go into an environment wanting to "fix" the issues for the family?
- Do you feel that you have all the knowledge?
- What kind of questions would you ask, open or closed?
- Do you acknowledge the parent's level of expertise (their child/condition)?
- How do you respond to parents if they are angry, upset, distressed?
- Do you acknowledge what you do not know?

INFORMATION AND EDUCATION: YOU NEED IT IN WRITING AND SHOWN

When a baby is born with a disability, or when parents come to the realisation that something is wrong with their child, life becomes a journey of discovery. There are times when all is well and the family lives a life that is perhaps similar to that of any other family. However, there is a period of adaptation when parents oscillate between the different stages of grief: these include shock, denial, anger, sadness, bargaining, and depression. Grief and reality can impact on individuals when they least expect it. Jane remembers having panic attacks at the supermarket:

> I could see the car … could not get there … bawling … that was when I knew that I had her for the rest of my life. (Jane)

There are realities concerning the future, the realisation of what life is going to be like with a child who has a disability, and all that it entails. Over the years questions arise which need to be answered in a timely and appropriate way. Jean (service provider) spoke about her perceptions of the thoughts and feelings about their children of families she worked with, offering the following parent's quote:

> I have had a child for 18 years or 21 years, still changing nappies. Am I going to change nappies forever? (a parent via Jean)

Jean spoke about children with disabilities not experiencing the normal rites of passage that children without disabilities go through. The children would not leave home, go to work, they would be forever dependent on their parents and the future did not bear thinking about for Debbie (a parent):

> Other parents find that the children grow older, get married, go away, have grandchildren, all rewards of being a parent, but they will be a parent forever. (Jean, service provider)

> Planning for the future … And that is the greatest fear! (Debbie, a parent)

Grace (service provider) commented that families' levels of stress and vulnerability varied across their children's lifespans. Initially, she felt that parents with young children (under 6 years) experienced difficulties, sometimes with no diagnosis or support, that made it harder for all involved, especially when parents were grieving. At this time the emphasis was on therapy, the child was the focus. Parents turned to each other for support as they shared a common bond and felt they understood one another at a time when they were overwhelmed:

> Parents are grieving, in denial, professionals say to them: you need to do this, have therapy, go to specialist services – they [parents] don't want to know anything is wrong with their child, there is pressure then. (Grace, service provider)

These families needed access to appropriate and timely information, to enable them to gain the most suitable information. Early in the child's life parents may require referral to a grief counsellor or psychologist, education about their child's disability, and later they may need respite services to enable them to have a break or spend time with their other children. But parents often found it difficult to navigate the system when looking at services for their child and wondered where to begin, when it resembled a maze (Australian Government Department of Social Services, 2011). Many parents experienced a range of mental health issues. Jean (a service provider) felt that there was so much that families were confronted with:

> What compounds that frustration that leads to the depression is the fact that there is nowhere to go to find out what you need, you have to begin a journey like a jigsaw puzzle, always pieces missing. Families wear out trying to find services out there. That's a huge issue. (Jean)

Lack of services and supports and ways to navigate existing services resulted in parents struggling on their own, especially with lifting and moving the child with a disability. Families highlighted back and neck pain and joint problems. Service providers witnessed these issues, along with tendonitis, use of wrist straps or support bandages, and even instances of arthritis in young parents. A number of mothers commented that their back pain worsened as time went on, especially as the child became heavier with age.

> Lifting him [son] my whole body aches, my back, just everything is hurting from carrying him around … 12 or 13 kg. I actually need to go to a physio 'cause I've got this pain up here [points to back] that is constant, yeah … just a matter of me making the time to do it. (Kristie, a parent)

Hoists were not often used to lift children out of wheelchairs because the house was not equipped for them. Amy (a service provider) spoke of a parent who managed alone with her child, and how lifting was a constant activity for parents. Written instructions were required, or needed updating, for safe lifting and positioning of children. Families had forgotten or disregarded a physiotherapist's instructions, often provided in a quick training session long ago, if at all. The families wanted to be shown quick and easy approaches, with follow-up.

REFLECTIONS: WHAT CAN BE DONE

The families found themselves in situations they could never have predicted, with no preparation prior to the event and so much to learn, often through trial and error. They cared for their children 24 hours a day, managing complex physical, behavioural and mental health issues including complex seizures and eating difficulties with limited education and support. These mothers all came from English-speaking backgrounds. Imagine how these challenges would amplify if they were from a different cultural background, new migrants or refugees. When accessing information there is often an assumption that everyone has a computer and the internet, and has time to search for information. The mothers were "time poor". They spoke about the trauma of opening unknown websites that displayed graphic images of the worse possible scenario with regard to disabilities – late at night and with no support. The families appreciated being offered up-to-date information; they attended seminars and conferences when there was timely notification and child care available. They appreciated professionals who were approachable, insightful and empathic. The mothers wanted to know as much as possible, to be able to ask questions without being made to feel inadequate, because this helped them to make informed decisions about their child.

SERVICES FOR CARERS: BETWEEN A ROCK AND A HARD PLACE

The mothers perceived that the real scenario, their "lived experience", was invisible to everyone except themselves. Attitudes of service providers had a huge impact on some mothers who felt they were not taken seriously or treated as equals. These mothers felt ignored, that their feelings were not understood and that they had to "make a noise" to be heard. Others felt exposed and vulnerable:

> You're naked to all of these people who are involved with your child and you want to be trusting of them and hope they're not going to abuse you but you know that they talk about you behind the confidentiality. You do feel very, very vulnerable. So when somebody around a committee meeting patronises me I shrink instead of looking up to them and saying, "Look, you haven't got a clue". (Jane, a parent)

Service providers often appeared unaware of the plight of families. While parents described services provided to the children as "great", their needs as parents were invisible. One family placed the child in a respite service for a break but were called out four times in a week as the child kept absconding. The parent had provided staff training and behaviour management plans, but still issues remained.

> The staff are not in touch with the journey that the person has travelled, families not acknowledged for what they do. (Tanya, service provider)

One of the most poignant moments arose when one mother talked about her role on advisory committees for a number of organisations that provided services to children with disabilities (early intervention, respite care). Jane felt she had to be on these committees in order to bring about change and support for her daughter. Jane had to find the money to cover childcare while on these committees as a volunteer, while professionals were being paid. Her husband had to work two jobs for the family to survive. There was no acknowledgement of her situation as a mother of a child with a disability. She realised that she was

> … supporting everyone else but not being supported. (Jane)

Families who had children with mental health needs often experienced difficulty gaining access to services to meet those needs. Service providers felt that the families were denied access to services because of the confusion about actual needs and who should provide or was prepared to provide the service, either mental health or disability services. The service provider felt torn:

> That [situation] puts us between a rock and a hard place, whether to service them and how that looks to other families. (Jean, service provider)

Children and young people with severe challenging behaviours were singled out by the services as too hard and too complex for them to work with. When the parents sought help, the responsibility was put back on them. The family felt that they had no choice but to carry on caring for their child. If they did not, they felt that the services would be taken away altogether.

> The service providers threaten to take services away, the family becomes silent, withdrawn, complete anxiety. [The parent] hears threat [from the service provider] become silent and withdrawn, anxiety escalates. (Tanya, service provider)

REFLECTIONS ON THE REAL PICTURE

I reflect on my thoughts at the time of interviewing these mothers. Jane initiated communication with me at one of the workshops. She was vibrant, intelligent, educated, and had a put a lot of energy into ensuring that services were there for her daughter and others in a similar situation. Yet Jane was one of the only mothers to cry and on more than one occasion. She spent her time supporting others but not receiving or accepting support, even when this was offered by her friends. This situation is repeated weekly as families advocate for their children. We were able to raise awareness of Jane's scenario with the organisations and she was reimbursed for child care costs when attending meetings. In this way, albeit through research, the establishment of an authentic relationship led to meaningful health experiences and outcomes for Jane.

THE IMPORTANT ASPECTS OF LIFE

Although this chapter has illuminated many negative and challenging health issues for families there is much that can be done. There are positive aspects of each family's journey that tell us what is important to them and can guide health practices. This selection of narratives comes from mothers of young adults looking back on their lives and emphasising the value of key relationships.

> Having a child with a disability also gives life a purpose. (Noelene, a parent)

> Husband is my best friend, we've worked really hard to create and maintain that. (Debbie, a parent)

> It's always been my friends who have been my sanity, they're the ones I cry with, they're the ones I laugh with. (Julie, a parent)

> What I said today I have not told my closest friends, but I've told Julie my friend [a carer parent] and the interviewer, but I don't tell my friends outside

> the disability area because they would be concerned about me and try and treat me. But with Julie I don't have that fear. And … unfortunately we probably always come together in a crisis time. (Gail, a parent)

CONCLUSION

In this chapter I have explored the issues of families who have children with disabilities from the perspective of the mothers and key workers. Families' needs for recognition and respect from health professionals from the beginning of their child's journey have been highlighted. Access to empathic professionals, grief counsellors and support groups will offer the families assistance at the onset. Education and information ensure that families are at reduced risk of injury or ill health when caring for their children. Addressing these areas can reduce the relentless demands on the parents (mainly mothers), the loneliness and aloneness of caring, and the subsequent isolation and invisibleness of their situation. Finally, it is often the families who are there for each other, passing on their wisdom and support, sharing resources, the joys and heartaches. We are the visitors in their lives, with a duty of care to do no harm.

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DIANE TASKER AND PETER JONES

15. IN THEIR SPACE

Healthcare at Home

People who suffer severe injury with disability receive rehabilitation in hospital but then are likely to go home to manage their disability with the assistance of family, carers and health professionals. People with ongoing healthcare issues want to live at home in a way that will develop their wellness and comfort and facilitate their access to the community. All stakeholders in such situations need to develop relationships that will help them achieve those goals. This chapter explores such healthcare relationships from the point of view of Peter, who has lived at home with a profound disability for over 20 years.

SETTING THE SCENE

Many studies report that people prefer to receive healthcare within their own homes (Barnes & Radermacher, 2001). Indeed, Svenaeus (2000) used the term "homelike being-in-the-world" (p. 90) to describe a sense of the state of good health. He was drawing from the work of the philosopher Gadamer (1996), who proposed that good health is not an introspective feeling but rather a state of being there, in the world with other people: "It is the rhythm of life, a permanent process in which equilibrium re-establishes itself" (pp. 113-114).

Since his spinal cord injury, Peter (co-author of this chapter) has lived at home with 24-hour care provided by registered nurses, assistants in nursing, family and visiting healthcare professionals. The healthcare provided for him is of a standard more often seen in a specialist hospital ward: highly customised and very person-centred, if not person-driven. When Peter attends hospital for inpatient care, his regular staff attend with him. Such a high level of care is required because Peter uses a ventilator to breathe via a permanent tracheostomy. His carers lip-read when he speaks. Although there is the option of using a speaking valve, Peter prefers not to, due to the discomfort it can cause. Staff attend to his face closely whenever he wants to speak, staying within easy reach to be ready when he wishes to say something. The registered nurses attending Peter "translated" for him during our conversations and added occasional personal comments (indented).

In Peter's following narrative, we explore some dimensions of professional healthcare relationships from his point of view. Professionalism places the interest of the client (patient) above that of the clinician and other third parties (Thirumoorthy, 2010, p. 23). To achieve such an aim, we need to hear the voice of the person receiving healthcare. The conversational narrative style presented in this chapter mirrors the background relational practice in Peter's situation. In such

J. Higgs et al. (Eds.), Health Practice Relationships, 127–134.

healthcare situations, healthcare practitioners necessarily spend longer periods of time (compared to hospital or clinic situations) with the person they are assisting and must adapt accordingly.

PETER'S EXPERIENCE OF HEALTHCARE RELATIONSHIPS

Healthcare Relationships in Hospital

When you go into hospital, you check your dignity at the door and become a *patient* rather than a person. Staff seem comfortable in their environment within the hospital but you are not. You can feel very vulnerable being sick or having medical procedures done. Sometimes people walk in on you when you are naked. It's like you're out on display. Ideally, *you* want to feel comfortable as well.

When I first had my injury I hated being in hospital, but the relationships I developed with my nurses there were good. Because I had a quadriplegia and needed a ventilator to breathe, I had one-to-one nursing care, a style of healthcare relationship that was quite beneficial for me. I didn't have to wait around for nurses to finish with other patients and this helped me escape the routine of a hospital ward and also gave me some control over the way *my* time was used. One of my nurses conspired to help me get through the morning routine as quickly as possible so I wouldn't get caught in the doctors' rounds. When I wasn't going to therapy I was outside sunbaking and talking with the staff around the hospital, having "time out". I knew all the spots to hide. I used to go up to the staff canteen, grab some lunch and go out and find a spot in the sun. If it was windy or raining, my nurse and I would just wander round the place. No one ever said anything to stop me. People get used to you when you are in hospital a long time.

Seeing the Person, Not Just the Condition

When I first had the accident I used to feel annoyed when people spoke over me, but over the years I have got used to it and I now just shrug it off. The majority of people apologise when they realise what they are doing, but it is nice when people speak to me directly.

Some people can't see the person with the condition. They are outside their comfort zone. They can only see the condition and its enormity. It's too difficult. It's like a shock, finding me behind my condition and recognising that I am just a normal person. I am not *the ventilated patient*. They have to get to know *me*. When I go back to hospital now, my staff are quite protective of me. For instance, when auxiliary staff walk in on me in the middle of my morning ablutions or speak to my carers instead of me, my carers will speak up to try and alter that behaviour. It is usually due to lack of education and/or experience.

Coming Home to Ongoing Healthcare

There was a lot of adjustment needed when I arrived home from hospital. Nurses attend me 24 hours a day and their presence impacts on all the family.

> Jackie (Nurse) added: Peter, do you remember how busy things were when you first came home? All the family was at home at that time; your sister was still at school and it was a very busy normal family household of six. It was a lot of work and effort trying to get everything sorted out and settling in. It is so much quieter and organised now after all the time that has passed and the work that has been done by everyone.

It was especially difficult for my family having people intrude into their personal space and even more difficult for mum. She is very house-proud and likes her home kept in a certain way. Carers don't mean to but they do move things around and put things in the wrong place. That is frustrating for everyone. Nothing is nurse-proof and if it can be broken, it will be. Home-based healthcare is an intrusion into family life, no matter how needed or wanted it is. The way we communicate with each other helps to ease that sense of intrusion.

The Ebb and Flow of Communication

Some staff are friends and some are more like family. They don't only have to feel comfortable with me but with my extended family as well. It would be a bit difficult having someone that I got on with, but my parents and siblings didn't. For example, I don't think that my siblings have to be everyone's best friend. Sometimes it can seem as though they are ignoring the nurses but it may just be in particular situations – like in the morning when they come down from their bed, or if they have had a rotten day. They may not always want to have a polite conversation with a carer. I've had comments about this in the past by one or two carers, feeling upset about it. I've told them that it is my siblings' home too and they (as nurses) need to "just get over it". My communication with most of my carers is pretty good. Some of them have been here so long they can understand what I am saying, even if they are standing behind me (particularly when I swear). Occasionally I can get quite frustrated. When there is a lot of people and I have something to say and no one is looking at me or paying attention to me!

> Cath (Nurse): It's not like you can talk over people to get their attention is it?

Sometimes one of my carers or one of my family will actually put their hand up and tell everyone to be quiet while I have my say.

> Di (Physio): How do you get people's attention, Peter?

When I want someone, I sometimes "click" my tongue.

> Cath (Nurse): The other day when we [the carers] were in another room, you went “click click click” on the control button of your power wheelchair – to get us to come to you.

I also tend to be more conscious of pronouncing my words clearly when there is someone new until they get used to the way I speak.

> Di (Physio): Its very upsetting for me as a therapist when I can’t understand something you are trying to tell me, Peter.
>
> Cathy (Nurse): Yes, you feel as though you are letting him down, don’t you?

Don’t worry. It’s one of those things that happens from time to time. Generally though, I have noticed that over the years, the way I communicate with people has changed for the better. People in public seem to be more willing to attempt to connect with me. I don’t know if acceptance of people with disabilities has improved but it does seem better.

> Cathy (Nurse): Perhaps also because we as carers insist on people approaching you and talking to you rather than to us.

Finding How Far You Can Go with Each Other

When new staff come in, it’s always difficult at first. They have to find their way around the relationship with me and my family. Both parties need to work at the interaction right from the start.

> Tess (Nurse): I also think that Peter tends to select his staff based on personality as well as competency. This may make it easier to bridge any gaps within the carer–client relationship.

I’ve got a fairly regimented routine so that is probably the easiest part for people to get their head around. When you’ve got someone new working, it’s the start of a relationship, talking about their past and my past. It’s about finding boundaries, finding how far you can go with each other. Some people’s boundaries are wider than others.

The building of relationships between me and my carers has its own natural progression. With some people, time makes the difference. With others, it’s like I have known them for years. Who knows where friendships come from? What is wrong with being close to someone you are looking after? (After all, I have family members taking on close and responsible healthcare for me.) People usually try to keep a professional distance from the people they are caring for, but in the home setting, healthcare professionals can find themselves in a close friendship with the person they are caring for. It happens gradually without them realising. When I was in hospital initially, the nursing unit manager was quite concerned that I was getting too close to one of my nurses. It caused a bit of friction at the time between me and that nursing unit manager. She tried to stop the friendship between us but it didn't work. She put my nursing friend on duty with other patients but we still got together for lunch anyway. We are still friends today, 20 years later. When I was younger I was more comfortable with female carers. Many of my carers are women and I have found that I have to be more careful of their feelings, which is something I had to learn. Only a quarter of my carers are male.

> Jackie (Nurse): Peter knows more about female menopause, menstrual cycles and pregnancy than most other men. We actually feel comfortable talking to him in a way that is different to usual healthcare relationships.
>
> Tess (Nurse): Perhaps we are just as exposed to Peter in some ways as he is to us in a physical way, when we are attending to him.

In the morning and the evening I have two people assisting with my care. I often just "zone out" until I see an opportunity to "throw a bone in" to get a response. It's just what you do with friends when you're talking. I am also a vault: when people share things with me, it doesn't go any further. You could also refer to me as the "northern star" or "the black hole" who sucks everyone in. Alternatively, people tell me that I could also be seen as an industry because my nurses receive pay which contributes to their family budgets – 15 families in total. Sometimes when I am in a mood, I tell my staff just to call me the "cash cow".

Blending Personal and Professional Aspects of Healthcare at Home

My nursing staff just blend in when I am socialising. I don't expect a separation between patient and carer roles when we are at social events. My carers are quite welcome to join in. That's why it is important for them to get on with my family as well as me. It's all part of the process. Most of my socialising is now with my family and carers. I have lost a lot of friends over the years. Some found it hard to get over my injury and some friendships just drifted apart. Perhaps because of my situation, it's easier to socialise with my family and carers. It's good for me; I hear about their lives and their kids. Many of my nurses have come and gone to have babies. I see photos and meet them at social gatherings. Some of their children have even come to work at my place with their mothers. This does change the relationship we have from just a professional one. It's good. I like to know what is going on in people's lives.

> Jackie (Nurse) muses: Peter always asks what I have been doing. It's not just coming to work. When I am at work or when I am out socially with Peter, I act slightly differently than in a usual nurse–client relationship. It's nice to be involved in a more personal way as well. It is a very specific atmosphere being here with Peter.
>
> Cath (Nurse): Peter is not sick so we don't always have to be his nurse.

It's Like a Dance: Balancing Power and Taking Responsibility

> Cath (Nurse): Part of the understanding when you come here to work for Peter is that you have to do what he wants you to. His mum says, "You are Pete's arms and legs. You have to do what he says". Pete will tell you in no uncertain terms if you try to push your view of how things should be done. One day he actually swore at his mum and us because we were being a bit bossy; poor Peter, he had three women telling him what shirt to wear. He had already said "no" and we hadn't paid attention.

Finding your way around each other can be difficult at times. It is different with each person and depends on what they are doing for you (nursing, physiotherapy, doctoring or other healthcare). There is no rulebook. When you have to deal with people for all aspects of your life, getting to know and trust them needs to happen easily. The way you deal with people, you could say it's like a dance. It's usually quite smooth but sometimes you step on each other's toes. Then you have to change your steps to be able to waltz on.

Over the years, I have seen a lot of people and I can usually tell fairly quickly whether it is going to work out or not. Sometimes I persevere but my first instincts are usually pretty good. If you don't feel comfortable with a person, it is difficult to progress your trust in the relationship. As people become more comfortable with me they can then make suggestions if they think something can be done better. It's up to me if I want to take it on or not and they are usually quite accepting of that fact. For example, when I was younger and at a party, I was drinking quite a lot and my carer was quite concerned about how much I was drinking. I said I was a grown man and not to worry about it. She also brought it up with one of my parents at the time and they said the same. She was still concerned but she accepted it.

> Cathy (Nurse): I rang the next day to make sure he was OK. It's a grey area. After all, Peter, you were doing donuts in the carpark.

> Jackie (Nurse): In general, if there is a course of action that I think is detrimental to him I will argue my point, but it is still up to Peter at the end of the day. I can't think of a situation when he has made a wrong call. If he wanted to make what I really thought was a bad decision, I don't know how I would cope with it but I don't think it would ever happen now because of the relationship we have. I think that Peter would take our strong opinions on board. It is all about the relationship.

Most carers know when they might be getting tired or "burnt out", and if they don't, I'll let them know. There might be problems within their families that are impacting on the work situation. In that case, those carers will usually change or drop shifts to decrease their stress. Over the years I have only had to let a couple of people go because of relationship difficulties. It was quite uncomfortable leading up to those situations but a weight off my shoulders when they had gone. I didn't realise the amount of stress that it had put on me, my family and other staff until later. It's a mixture of what's going on in their lives and their relationship with me.

Sometimes even the staff they work with can be affected. It can be extremely uncomfortable for everyone if two people working together have a disagreement that is not resolved. The room becomes uncomfortably quiet. It's important to have a comfortable relationship not only for me but also for those around me. That's the crux of it. If you can fit in with each other, then things go smoothly and I can relax. It is the ebb and flow of relationships, being able to fit in and feeling relaxed that makes it easier for us all to keep on working together.

REFLECTIONS

People receiving healthcare at home feel more confident on their "home ground". That increased confidence gives them a home-ground advantage when interacting with visiting healthcare practitioners who enter their client's space as guests in that client's home (Heckman & Cott, 2005). Such "visitor" status naturally includes social interaction to become comfortable with and know each other better. The person-centred approaches required for chronic and complex home-based healthcare are necessarily longer term in nature and require extra one-to-one time with clients. Increased opportunities can exist in such situations to develop strong relationships between clients, families and carers, which can contribute to better health outcomes for the client concerned.

In this chapter, we have drawn on the experiences of Peter and his long-term staff, who often spend 8-12 hours on a one-to-one basis with him. Although such close care relationships do not usually occur for clients in hospital settings, the one-to-one nature of Peter's hospital-based nursing care also encouraged the development of strong relationships with some of his nurses, leading to their continuing care of him when he returned home.

Healthcare provided by other practitioners, such as medical, dental, podiatry, pathology and other specialists, is usually quite short and therefore does not allow relationships between client and practitioner to develop in the same way as Peter's other carer relationships. Knowing and trusting in the careful and consistent provision of his healthcare gives Peter a more relaxed living environment and promotes his overall sense of wellbeing, that "homelike being-in-the-world" described by Svenaeus (2000). Although Peter does direct his care, he and his nurses work together to achieve desired results. Peter needs this different style of healthcare relationship to be able to live at home comfortably. He agrees with Frank (2002), who wrote, "The help I want is not a matter of answering questions but of witnessing attempts to live in certain ways. I do not want my questions answered; I want my experiences shared" (pp. 13-14).

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16. RELATIONSHIPS IN CLINICAL EDUCATION

"It Comes Down to the People More Than the Place"

The understanding of workplace learning (e.g. clinical education activities) as participation in authentic workplace activities underscores the importance of explicating the relational nature of workplaces in clinical education. This chapter draws on Narelle's doctoral research to illuminate the central role a range of workplace relationships have in shaping clinical education experiences and, consequently, learning outcomes. In clinical workplaces students develop meaningful relationships with a wide variety of people and use multiple workplace spaces to develop those relationships. The significance of these relationships and spaces or relational spaces to clinical education experiences is neatly captured in the quote from a physiotherapy student in the subtitle of this chapter: "It (clinical education) comes down to the people more than the place". This chapter explores the nature and importance of these workplace relational spaces through narratives that represent physiotherapy students' and clinical supervisors' perspectives.

SETTING THE SCENE

Clinical education, viewed as participation in a community of practice, privileges the quality of relationships developed between students and clinical staff. These relationships develop students' knowledge, skills and professional identity (Kyrkjebø, & Hage, 2005). The significant contribution of these relationships for students, evidenced through development of rapport, acceptance, appreciation and support of students while on placement, has been described in nursing literature over several decades (Courtney-Pratt, Fitzgerald, Ford, Marsden, & Marlow, 2012; Dunn & Hansford, 1997; Henderson & Twentyman, 2006). When students are not readily assimilated into the work environment and are viewed as guests within organisations they receive limited amounts of information, and their participation in activities and consequent opportunities to develop knowledge are also limited (Henderson, Winch, & Heel, 2006). In clinical workplaces students develop relationships with a wide range of individuals including clinical supervisors, patients, doctors, nurses, other allied health staff, porters, administrative staff, cleaning staff, and other students.

The importance of interprofessional relationships among clinicians and the value of long-term relationships formed between students and patients have been explored in other chapters. In this chapter, the influence of a broader range of workplace relationships on students' clinical learning is portrayed. The research that underpins this chapter was primarily undertaken in a metropolitan centre in

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Victoria and involved physiotherapy clinical supervisors and physiotherapy students in their second, third or fourth years of study who were undertaking clinical placements of five weeks duration.

RELATIONAL SPACES SHAPE STUDENT LEARNING

While students develop relationships with a broad range of people in clinical workplaces in this chapter we explore three key relationships: those that students formed with clinical supervisors, nursing staff, and patients. The focus of this exploration is on how these relationships are formed and the significant way in which these relationships shape student learning. Narratives and quotes from physiotherapy students and clinical supervisors (from Narelle's research) are presented in this section to illustrate how the formation of these relationships within clinical workplaces powerfully shape students' clinical learning. In this chapter all participants have been assigned pseudonyms with clinical supervisors assigned a pseudonym beginning with the letter C to assist differentiation between clinical supervisor and student perspectives.

Narrative 1: Relationships with Clinical Supervisors

Supervisory relationships, developed between students and clinical supervisors, are key to positive learning experiences and largely determine the level of student involvement in authentic workplace activities. This narrative's focus is on the way meaningful relationships between students and clinical supervisors are formed.

Narelle found that multiple workplace spaces were used by students and clinical supervisors to nurture the development of meaningful educational relationships. These spaces included clinical areas, physiotherapy lunch rooms, staircases and cars used to travel between work activities. The common thread linking these varied spaces was that they each offered a space for quiet conversations; in some cases these were clinical conversations and in other cases they were both clinical and personal conversations.

These quieter spaces facilitated the development of student-supervisor relationships. The students felt comfortable asking questions in these spaces and felt they weren't wasting supervisors' time. They appreciated the opportunity to ask clinical questions, to resolve any concerns they had regarding patient assessments and treatments and to receive feedback from supervisors regarding their clinical performances. This use of quieter learning spaces is encapsulated in the following quotes:

> I think the stairs were used in a good way … if your supervisor wanted to talk to you about a patient … the stairs weren't super busy … a good place to have a more quiet chat and you can do it while you are going somewhere so you are not wasting time. (Sophie)

> Definitely some feedback (was) provided on the stairs … small things like you did that really well or you could have said this or you forgot to mention that … it was good. (Tom)

Importantly, both student and clinical supervisor participants in the research highlighted the value of less formal environments (for example during car travel) in supporting casual conversations. Casual conversations also dealt with students' and supervisors' social lives and this was seen as important in developing good rapport between students and supervisors, which ultimately empowered students to ask questions. In these more relaxed spaces students were more likely to discuss any issues or problems they had encountered during the placement. These issues and problems could be both personal and professional in nature. These discussions were important because when clinical supervisors were aware of any issues or problems that individual students had encountered they were able to adjust placement parameters accordingly. The less formal environment created by car travel between work activities contributed to the development of meaningful relationships between students and clinical supervisors, as illustrated in the following quotes:

> Because you have spent so much time together and you talk about your family … you feel more comfortable to talk about any problems you are having and any questions as well. (Tess)
>
> I have the student come to hydrotherapy with me … that's a great opportunity … just be open about any issues they're having … often we'll just talk social stuff … puts the student at ease. (Charles)

While the clinical supervisors were aware of the need to share both their work and recreational areas with students, the sharing of recreational spaces created a tension for some supervisors. The supervisors were sometimes conflicted between their need to maintain a professional persona with students at all times and the acknowledged benefit of students knowing them as people as well. This tension between being known by the student as a person and keeping a professional distance is neatly described by Caroline in the following quote:

> It's a tricky thing; we would be definitely saying that they are welcome to join us for lunch and we have a table and bean bags basically and the students would often head down to the bean bags and the lounging area. Often students though would prefer to go to the café to have a bit of a break; students often go to the café just to be away from us, it depends on what they want to do. I think it's good that they can feel welcome and having said that clinicians also need a bit of a break sometimes. So we're not overly concerned if they don't want to sit with us and that's fine too. I think they see us as normal people, you know that we talk about the dog that got out or you know whatever happens at home. I think that there definitely has to be professionalism and respect between staff and between students and staff. We have to be careful to keep a professional persona on sufficiently. I guess that's sometimes why we are happier that students aren't necessarily there [in

> our lunch room] all the time because we would like to crack some jokes sometimes. Then we prefer students are not there but I think it makes them know that we are people just at work and work life balance and this is a job right from the word go. It also means that they are going to approach you more readily if they feel you laugh as well as being serious. (Caroline)

Narrative 2: Relationships with Nursing Staff

Among the various health professionals working in clinical workplaces, nursing staff were identified by the participants in Narelle's research as being particularly significant to the physiotherapy students' clinical learning. Interestingly, the students and clinical supervisors did not regard nursing staff as gatekeepers to patients and practice, a view that has been reported in previous research (Dornan, Boshuizen, King, & Scherpbier, 2007). Rather, participants highlighted the significant contribution of nurses' wealth of knowledge and their ability to provide physical assistance, as required, to students' learning. The participants held nursing staff in high regard and identified a strong need to establish and maintain positive relationships with them. However, maintaining positive relationships with nurses was not always easy and required "finding the balance" in time spent between assisting nurses and completing physiotherapy work. Students often required assistance from clinical supervisors to navigate the complex and often confusing territory of establishing and maintaining positive relationships with nursing staff.

Input from nursing staff facilitated students' ability to develop more accurate assessments of patients' functional abilities. The students also often asked nurses questions when their supervisors were unavailable; nurses not only answered but also often provided valued advice. This important role of nursing staff in answering questions and providing advice to students is shown in Scott's and Carl's quotes:

> If you ask them [nurses] they are more than happy to tell you how the patient is going and explain the charts or why the patient can't get up today … or suggest what I could do. (Scott)

> I have seen nurses in our environment giving valuable advice in a constructive way to the students. (Carl)

As well as possessing a wealth of knowledge, nursing staff also provided a valuable source of physical assistance during patient interventions. The assistance provided by nursing staff contributed to increased safety and time effectiveness when students undertook patient assessments and treatments. For example, nurses often helped students with patient transfers, provided assistance when patients suddenly became unwell during mobilisation (including cleaning up vomit), and relocated accidentally dislodged intravenous lines and indwelling catheters.

The participants held a high level of respect for nursing staff and expressed a desire to maintain the high standards set by nursing staff on the wards. The students stated that they felt motivated by exemplary practice demonstrated by nursing staff on particular wards, as evidenced in Sam's quote:

> Nurses … they are it, they are everything, I think they are brilliant … so kind and so genuine towards every patient … easy to talk to … they genuinely care about the wellbeing of the patients … a beautiful way to be … you then want to do the best by the patients and keep up with the standard. (Sam)

The centrality of nursing staff to healthcare in hospitals and to these physiotherapy students' learning meant that relationships developed with nursing staff were considered critical to efficient and effective physiotherapy practice as well as student learning. It is not surprising, therefore, that students often went to extraordinary lengths to establish and maintain positive relationships with nurses. Narelle's participants highlighted the importance of reciprocity in the development of positive relationships with nurses. Tasks identified as nursing tasks that both physiotherapists and students completed in order to maintain good relationships with nursing staff included helping patients to don anti-embolus stockings, tidying beds, getting pans for patients, taking patients to the toilet and getting linen for patients including towels, sheets and blankets. Both clinical supervisors and students highlighted the importance of assisting nursing staff even if it meant undertaking tasks they did not enjoy, as evidenced in Greg's quote:

> Our physios were very much for "help the nurses as much as you can, do as much as you can for the nurses", and I had to drain a urinary catheter and I wasn't too pleased about that. Definitely an eye opener! (Greg)

This perceived need to assist nurses in order to maintain positive relationships led to students often experiencing difficulty in finding an appropriate balance between helping with nursing work and completing physiotherapy tasks. Often intervention was needed from supervisors to "adjust" the student-nurse relationship to ensure that students could complete their own work as well as assist the nurses. Students' need for assistance in balancing their relationships with nursing staff was demonstrated in Meg's and Monica's quotes:

> You try and stay on their [nurses] good side but you can only do that for so long before these people need physio. (Meg)

> Every time a nurse saw me … come here and help me do this … I was seriously just their little run-around gofer. So I actually did … (talk) to my physio … so they had to talk to them. (Monica)

The participants' high level of respect for nursing staff in general was tempered by acknowledgement that nursing could at times be a complicated profession. This complex situation further challenged students' ability to establish positive relationships with nurses, as seen in the following quotes.

> Nursing … can be a tricky profession sometimes. If you don't approach it the right way … things are sometimes more difficult. (Craig)

> You have to be very tactful because you don't want to get on their toes because they are always there. They are spending a lot more time with the patient than you are and so you need to be very, very, very careful. (Stacey)

Narrative 3: Relationships with Patients

Clinical placement experiences are often acknowledged as offering prime opportunities for students to relate theory and practice as well as develop knowledge from being in practice. Engagement with authentic patient activities is an important element of placement experiences that extends students' knowledge far beyond propositional knowledge (theory) and prior learning, progresses the learner's practice capabilities and contributes practice knowledge to the field. Narelle's research revealed that authentic patient interactions improved students' ability to understand medical conditions and their impact on people's lives, to solve problems and to refine physiotherapy practice skills. Given this impact of experiences with patients on student learning, the focus of this third narrative section will be the manner in which students establish and nurture relationships with patients.

In this narrative Sarah reflects on how she established rapport with her patients, appreciated the benefits of establishing rapport for completion of her physiotherapy work and sought to achieve an appropriate balance between time spent establishing relationships and completing physiotherapy work.

> I've seen so many patients that I know, so many people, mainly because I am with the oldies and their grandkids come in and I know them. It's really nice because it means you can have a bit of a rapport automatically with the patient because you say, "Oh George and I went to school together", and you can about talk that. But it's interesting, I think a lot of the time you need to be quite impartial to the patient and its harder to be impartial that way. You know when a patient really doesn't want to get up and they're in a little bit of pain you have to kind of manipulate them a little bit to get up and you have to be a bit mean, almost. If [the supervisor] wasn't there half the time I wouldn't get a patient up. He's like (saying) – "no they need to get up", but they are hurting and they don't want to or they are feeling quite nauseous or whatever. I suppose it reminds you that they have got family too and they're genuinely not feeling well whereas I think – after a little while I think - you can become very blasé about that. I also think that you have to temper that with time constraint and the reality that you are in a public system and you need to see 30 patients a day because it's unfair to the others that you don't see them - if you actually spend a bit more time chatting with them and building rapport and really getting to know them. And often I find [my supervisor] just goes in, (and talks to someone) he's never seen someone (and says), "Hi I'm […], I'm your physio and I'd like you to lift your legs in the air". … I think you've got to find that medium between being safe and also doing what needs to be done for them – for their bigger general health. I don't know, I haven't quite

> worked out where I stand where I feel about that. Be their friend, be friendly but not allow them to waffle on because (then) I think they are not going to do anything (therapy). In reality you can't actually force someone to get out of bed. If they are not actually going to move their limbs – you can't (make them) do it. So I think that at some level you have to build some rapport to be able to do … (the therapy) and to be able to maintain their dignity. I mean they are still people and I am still a person and I don't want to be treated like that … I think it is common decency. (Sarah)

REFLECTIONS

The above narratives have illuminated the integral contribution of workplace relationships to students' clinical learning during placement experiences. This centrality of a range of workplace relationships to student learning highlights the innate humanness and relational nature of clinical practice and clinical learning. We contend that consideration of *relational spaces* within clinical workplaces and their influence on student learning as well as student and supervisor wellbeing offers a useful way forward in the development of positive, effective and sustainable clinical education experiences for students.

These *relational spaces* within clinical workplaces, while being central to student learning and practice were not always experienced as easy or comfortable spaces. For example, in these spaces both students and supervisors experienced tension between a need to know and be known as a person and a need to keep a professional distance. Interestingly, in these narratives this tension was not fully resolved which highlights the need for explicit discussion and clarification of this personal and professional dynamic in professional relationships among professional practitioners and those responsible for professional education.

Finally, the complexity of workplace relationships and the amount of work required to establish and maintain these relationships should not be underestimated. In these narratives both students and supervisors worked hard to establish and maintain these highly valued relationships. This has implications for the manner in which educational programs prepare students for clinical placement and professional development programs for clinical supervisors.

CONCLUSION

Relational spaces that occur within the context of workplaces and clinical education have the power to influence student learning and professional practice. The inherent humanness and consequent tensions within these powerful and complex spaces have been portrayed in this chapter. Framing clinical education as *being in relational spaces* provides a useful way forward in the development of clinical education experiences that embrace and harness the inherent humanness of both professional practice and clinical education. Such education experiences would privilege the development of students' capability to nurture authentic health practice relationships with other health practitioners and with patients and thereby achieve meaningful outcomes for those with whom they work. As one clinical supervisor participant in Narelle's research reflected:

> We are humans. They've [students] got their story underneath that veneer and we don't really know what that is. (Christina)

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17. INTERPROFESSIONAL RELATIONSHIPS IN HEALTHCARE PRACTICE

Successful interprofessional relationships in healthcare practice are a foundational aspect for promoting collaborative healthcare. Mutual intention and common goals among individual health professionals are the building blocks to initiate the development of these relationships. This narrative outlines the development of a unique relationship that evolved from the motivation of two individual health professionals who had a desire to practise together. The description provided defines the key characteristics and experiences that influenced the development of this relationship. The narrative is constructed using the paradigm of eating disorders, the complex area of care through which these health professionals relate.

SETTING THE SCENE

Working with complex clients requires strong relationships between the health professionals involved in their care. This chapter provides an insight into the importance of interprofessional relationships when working with eating disorder clients. The core relationship described exists between a general practitioner (GP) in private practice who has specialised training in eating disorders and a dietitian working in the public health sector. A unique partnership has formed between these two clinicians over the past 21 years. Other interprofessional relationships have developed with a range of health and academic professionals who have interconnected with the original partnership over time. Through the development and delivery of a continuing professional educational program called Nourishing Networks (Little et al., 2012), the established relationships created a closer and more diverse network. This network consisted of general practitioners, dieticians, mental health nurses, psychologists and school counsellors. Key academic staff involved in this educational program were from mental health nursing and dietetics backgrounds and employed in the local university.

These relationships exist in a regional setting of northern New South Wales, Australia. The population of this centre is approximately 50,000. Healthcare services based in this area include a tertiary rural referral hospital, private hospital and a range of private health practitioners. Specialised medical services are often provided on a fly-in-fly-out basis for oncology, psychiatry and rheumatology. The nearest metropolitan hospital is 300 km away, with complex critical cases being transferred there. Typically, there are limited specialist services for eating disorder clients living in rural areas, who often need to seek care in metropolitan areas.

J. Higgs et al. (Eds.), Health Practice Relationships, 143–152.

Rural health professionals are often required to take on leadership roles in some complex clinical areas and to develop specialist skills.

PRESENTING THE NARRATIVE

Development of the Relationship

The relationship first developed from a clinical need reported in a simple referral from a GP to a dietitian that led to a connection over an individual client. Each client referral initially occurred through phone calls because of the immediacy and complexity of the cases. Over time, the GP and dietitian recognised the value of their interactions and the need to build depth beyond their original connection. From this point, the relationship developed further to where it exists now.

> I started talking to [dietitian], in '92 and that's how we met … we started to share some patients and then we decided that we were spending a lot of our time talking about these patients, we should formalise this process … so we started having lunch and it kind of rolled. (GP)

The GP and the dietitian realised they had a common interest and a passion for dealing with eating disorder clients, combined with the recognition there were few health professionals in the local area who had this interest. They both had a desire to make a difference and develop a standard of clinical expertise for their clients' benefit. They shared common goals for their own practice and also for their professional development.

> We both had a desire to do something in this area [of practice] … everybody was happy to leave eating disorders alone … it was a hard area of medicine … we questioned how do we learn the skill set around this … we grew in our knowledge together. (GP)

> In some ways we were forced, but not in a negative way, together because of our mutual interest and need to work together around eating disorders. We probably both didn't hold hard and fast to those socialisation rules around "a doctor should practise X and I need to speak about X, and a dietitian should practice Y and only speak about Y". So the fact was that we gave each other space to move in and out of the different health socialisations, which made the relationship. (GP)

The informal meetings between the GP and dietitian commenced in 1992 and continued until 1998 when they expanded and became more formalised. The meetings expanded further when other GPs began to notice the relationship and became interested in what they had established. In 1998 the GP and dietitian started to incorporate a triad approach to care (for further reading see Joy et al., 2003) by inviting a psychologist into their meetings. The dietitian and GP remained the consistent members in the group, with various psychologists participating over time. The inconsistent engagement of psychologists working in the triad of care was due to a lack of financial remuneration for psychologists for case conferencing and staff retention issues.

Between 1998 and 2009, prior to the development of the Nourishing Networks program, the dietitian and GP developed their expertise and gained a profile locally for their ability to manage eating disorder clients. This led to an increased number of client referrals and an increased caseload. To deal with the increasing workload the GP and dietitian focused on the professional development of others to increase the workforce capacity for this specialist area of practice. “Because I got referred a lot of eating disorders, many of them didn’t need to be seeing me, they could be co-managed by other doctors” (GP). The leadership of the GP and dietitian in the area of eating disorders became further recognised. An unintended consequence of their desire to increase the autonomy of other health professionals working with eating disorder clients through the provision of education was an increasing demand for their expertise. “We really needed to up-skill more people as we were getting too many referrals. We were at capacity basically … but all that was happening was that people were much, much better at identifying them” (Dietitian).

Development of Nourishing Networks

In 2009 the Nourishing Networks program was developed through conversations between academic staff at the local university. Academic staff with backgrounds in mental health and dietetics were investigating opportunities for rural health education grants. Eating disorders, as a mental health issue, provided an ideal topic for interprofessional learning due to the complex nature of the disorders and the need for a range of health professionals to provide care (Little, 2012).

There was a strong existing relationship between the GP and dietitian clinicians and two academics. A relationship between the mental health academic and the GP had previously developed through mental health training. As a result of this initial contact, they continued to work together in a training capacity and their clinical relationship strengthened. “Because we had this previous working relationship I felt comfortable contacting her. We worked well together because we were both highly flexible and there had to be an element of trust and respect” (Mental Health Academic).

The relationship between the clinical dietitian and academic dietitian started through collaborative work that developed into friendship and an ongoing professional relationship. “A working relationship evolved into more of a friendship and as result the working relationship was very easy. I think we understood and respected each other” (Academic Dietitian).

The connections between these four health professionals occurred through the development of the Nourishing Networks program. Although these professionals were based across three different settings – tertiary education, primary health and public health sector, this did not negatively influence the connectedness and purpose of their relationships. Each individual in these dynamic partnerships had a clear understanding of the roles that existed within the different work environments. This knowledge promoted the depth of the relationships and the flexible nature of the interactions. Figure 17.1 shows the connections across the professions and settings. (Note: MH=mental health, GP=general practitioner).

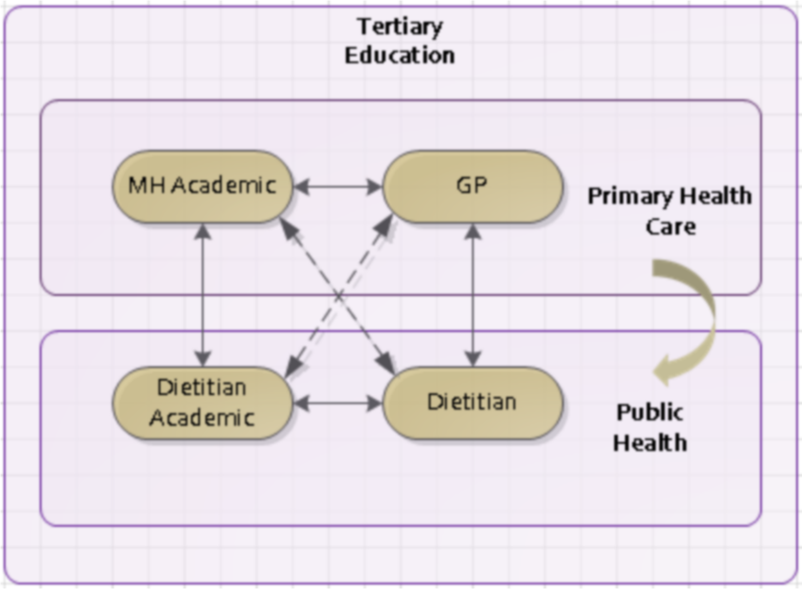

Figure 17.1. Relationship diagram

It was anticipated that the Nourishing Networks program would lead to an increase in interprofessional collaboration across a number of health professionals involved with eating disorder clients. The barriers faced by GPs in accessing training within working hours created a limitation to interprofessional collaboration across all disciplines. Networks across other sites developed, but the dynamics changed from a small local interpersonal group focused on case management to a large formalised group of less experienced clinicians. The motivation of group members went from providing debriefing and support around case management to health professionals seeking to advance their skills and learn from the expertise of the original small group members.

> Meetings now have evolved into a lot more education for others who aren't as *au fait* with eating disorders and didn't actually have clients; they felt that we shouldn't be talking about clients because they weren't part of the treating team … and so the nature of the meetings changed, it became less relevant to me. (GP)

Subsequently the dietitian and GP tried to recapture the partnership they previously experienced. They determined that in order to do this effectively they wanted to examine the new group's expectations and needs. Dietetics students undertook an evaluation of the group in 2009. This evaluation found that newer members wanted more continuing professional development and were not necessarily treating eating disorder clients themselves. The new larger group was essentially different from the original small group. It no longer satisfied the needs of the original members and increased the burden on the more experienced health professionals involved. The original relationship between the GP and dietitian continued behind the scenes to re-establish the supportive relationship that had existed previously but had been lost through the expansion to a larger group with its varied expectations and needs.

> It was very much peer support, that was probably the need … recognising that working in this field you need to support each other in doing it … you need to debrief … then also encourage each other to continue doing the work … we'd lost that …. I'm happy with my own patients, I'm not happy to look after the world's. (GP)

Interprofessional Approach

An interprofessional approach is important to the treatment of eating disorder clients and is often referred to as the triad of care (Joy et al., 2003). A clear understanding of the roles of each profession within this triad is paramount to ensure that clinical boundaries are not crossed. Good communication between professionals is essential to minimise inappropriate client influence on treatment and to optimise health outcomes. The difficulty is to ensure that while maintaining professional boundaries the interprofessional approach is not lost. "The limitations of the best approach for your eating disorder clients is that triad approach where you actually have a team" (Dietitian). It is about understanding each other's roles and how they contribute to client care. In addition to an understanding of roles it is also about gaining credibility, being accessible and having a professional reputation. These factors reduce barriers to working collaboratively and facilitate quality client care.

> One of the things a medico has to be very careful of is that you don't spill completely into the psychologist role or the dietitian's role as well. Our job is physiological assessment of their health to make sure the patient is able to work with dietitians and work with psychologists to regain health. (GP)

> There was a 12 year old girl from another town that I didn't think [GP] needed to take on, but I desperately needed some medical input, so I rang the paediatrician and they took her on without even blinking … now we've got that mutual respect and they really have a much better picture of what we do. (Dietitian)

In this area of practice it can be difficult to access clinicians with relevant experience, let alone expertise. This is particularly relevant for rural areas where there are fewer individual professionals. When specialising clinically there is often a need to seek out other clinicians to reduce the isolation that occurs from that specialisation. “Co-ordinated care is difficult in a rural environment, whereas when you are in a [specialised] unit, all the clinicians are in one little building, they do case conferencing, it’s all very formal” (Dietitian).

Collaborative care across sectors in health requires an understanding of how different health systems operate and the barriers that exist to accessing care. Understanding the differing demands between the public and private health sectors and the values underpinning the approach to care will enhance the opportunity to have an effective working relationship. “We work in two different spaces: the public and the private … the relationship that we have is unusual … because of the personalities and the investment we both have into this role” (GP).

There are many barriers to working interprofessionally, including competing work demands and liaising with other clinicians, of which the latter is time-consuming. Some clinicians are reluctant to engage with others due to a lack of understanding of each other’s roles or to concerns about possible challenges to their own role and expertise. The development of formal pathways provided clarity for roles and responsibilities which created permission for liaison to occur between health professionals.

> Time is one of the challenges [to work interprofessionally], it’s also challenging us to move and think in a different space, which I think some people are happy to do and others are not. Others don’t see the point in it. Some people perceive they’re conceding their space. (GP)

Stigma of Eating Disorders

A barrier to health professionals working collaboratively with eating disorder clients is the fear that some of these professionals associate with adequately managing this client population. There is need for a sound understanding of the influence of stigma with this client group in clinical practice and the potential barriers this creates in working with other health professionals or families.

> Initially for some people it’s fear around how unwell these people are … fear around not knowing what to do … fear about dealing with families because often by the time they’ve come to the doctor the family is in crisis and they’re very reactive and often very demanding and it’s around fear, for everyone. (GP)

> I actually spend a lot of time talking to my staff about how to ask those awkward questions… how to say it and how to appear less stressed about it. I think the stigma is such a hard thing because people get so phobic about seeing an eating disorder [client] before they have even seen them. (Dietitian)

Preconceptions about the underlying causes of eating disorders can affect the willingness of health professionals to work together. When one clinician can communicate and develop insight into another’s role, this can reduce the stigma associated with the eating disorders client group and improve clinicians' willingness to work together. Stigma can also work to create closer working relationships between health professionals who do understand that it exists, because that understanding is rare.

Interpersonal Aspects of Collaborative Relationships

The key interpersonal values that make interprofessional relationships work include respect, honesty, trust, and a commitment for the common cause that the relationship is founded upon. These values play a role in setting the dynamics of interactions between clinicians. A continuing desire to maintain the relationship is based on mutual benefits and reciprocity. Superficially, people can work interprofessionally by exchanging referrals and providing expertise, without any real interpersonal exchange. When there is a relationship based on underlying values, it gives a depth to the finer aspects of the interprofessional relationship. The ability to put aside professional labels and preconceptions and accept the expertise other professionals can contribute to effective relationships and consequently optimise client care.

> I think also if you start to work in interprofessional spaces, there's a danger that people get worried about their turf or their territory … there was a professional openness, so an acknowledgement to understand what each other does, but with mutual respect. (GP)

Mutual enthusiasm and the desire to produce best-practice outcomes for clients require consistency that is driven from commitment and passion. Having realistic expectations of what can be achieved with client outcomes can help maintain a desire to continue to provide clinical services, particularly in a challenging field of practice with limited success rates.

> If we were going to put all this emotional energy into it we had to do it properly … we had enthusiasm and passion about working in this space. We've had some successes and successes breed the desire to continue to work and we are both committed to working there. (GP)

> Passion can also be a barrier because with that come implied expectations and that may put others off if they don't feel competent or have the same level of drive. (Dietitian)

The values of openness and respect led to a willingness to reciprocate in sharing knowledge and skills based on the foundations of each professional's background. Traditional barriers need to be broken down to allow professions to learn from each other. "I think we challenge each other to maintain our skills in that area [eating disorders] … there's a mutual respect and a professional respect … an understanding that I can say whatever to her and she can say whatever to me" (GP).

Considering the complexity of health practice relationships, obtaining and maintaining effective interprofessional relationships takes considerable effort. The value of the personal approach is key to developing these relationships. "It's that personal connection that can make a difference" (Dietitian). Finding a balance between personal and professional connections helps to maintain the depth and quality of the relationship without diminishing the boundaries that are needed to keep the focus on the working relationship. Being goal-directed ensures that the purpose of the interaction is not lost within the relationship.

> There's a personal friendship as well, but around professional work we've never blurred the fact that that's actually what we do together. When we meet it's still around what you're doing with your patients and how it's working with them. (Dietitian)

Nurturing the relationship is about "checking in", about being intuitive to support others to recognise their need for self-care and looking out for each other. The existence of trust and honesty in the relationship gives permission for those in the relationship to admit to their own vulnerability. "We don't ask each other to be infallible, to be indestructible. There's a recognition that it is okay to say this is actually really tough" (Dietitian).

Supporting and nurturing each other in tough times allows for rejuvenation and validation, particularly when there are feelings of helplessness about what can be achieved when dealing with difficult client situations. An interprofessional relationship that is founded on sound values can have an important role in debriefing. When this occurs across disciplines it allows different perspectives to be considered.

> Years ago we had somebody die and it was the most awful thing, but I can remember us having our meeting and both of us sitting there going, "this is terrible", but we talked it through and I left thinking, "that's okay, it's back in its place, back in its box and I can see the next ten people and not be dwelling". (Dietitian)

A desire to care for others and an appreciation for good client outcomes contributes to health professionals' sense of self-worth. When working with complex clients there is less likelihood for positive feedback from the client and hence the clinician needs validation elsewhere. When strong interprofessional relationships exist there is less need for "external" approval.

> Looking after each other … perhaps that's why the interprofessional relationship becomes so very important, because it nurtures us to continue working in quite difficult and sad spaces, where we don't always get thanks or approval or acknowledgement from patients and families. (GP)

REFLECTIONS

The narrative presented in this chapter provides an example of how health professionals can develop productive interprofessional relationships. The key relationships described in this narrative were developed from the necessity to find common solutions to healthcare problems, and to cultivate mutual support not otherwise accessible. This derived from a need to provide care and treatment that went beyond conventional levels for eating disorder clients.

This narrative demonstrates that an intention to work collaboratively towards a common goal provides a sound basis on which to begin to create effective interprofessional relationships within the healthcare setting. An attitude shift and openness from individuals to working with other professionals is needed, to consider what others can contribute to one's own professional practice. Opportunities for this may be focused around complex clinical cases and the need to provide specialised client care. However, the intention to readily liaise with other health professions need not be limited to situations that require advanced levels of practice.

The socialisation of health professionals in their undergraduate and postgraduate training can influence their willingness to develop collaborative ongoing partnerships and their desire to work interprofessionally. This is often defined by the pedagogy of one's profession and how this relates to the theoretical foundation of the training of others. It is important for clinicians to question how they see themselves working with other health professionals, to explore ways to more effectively engage with others and to improve interprofessional communication. The development of respect and understanding of others' roles and a focus on synergy, rather than protection of professional boundaries, has the potential to improve interprofessional relationships. This could ultimately initiate a move away from working in a profession-specific paradigm, to a more collaborative team based approach.

Individual health professionals who choose to work collaboratively face potential risks due to the vulnerability associated with people's self-perceived capability in their own professional field. Recognition of the benefit of established credibility between health professionals needs to be contemplated and overcome for novice health professionals to adopt interprofessional interactions more readily. It is important to reflect on how health professionals view and think about other clinicians and their roles in client care. To challenge your practice to be truly interprofessional, consider the following: Do you really understand others' roles and how they can interrelate to yours? Who else could you be working more closely with? How do you do this respectfully and in synergy with others? There are considerable benefits to be gained from working collaboratively, particularly improved client care (Reeves et al., 2005). In order to achieve this, health professionals and services need to develop spaces and networks that foster interprofessional interaction.

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KYM M. RAE AND LORETTA WEATHERALL

18. RELATIONSHIPS IN INDIGENOUS HEALTH PRACTICE

Long Conversations and Embraced Vulnerabilities within the Gomeroi gaayngggal Centre

It's about connecting all the mums and the community.
It's about connecting community and health. (Loretta)

> For the purpose of this chapter, the term Indigenous refers to Australian Aboriginal and Torres Strait Islander people. The term Aboriginal is used by the authors when referring to their local communities which contain limited numbers of Torres Strait Islander people.

Improving health outcomes for Indigenous people of Australia has become a key priority for health services and organisations since the launch of the *Close the Gap* campaign in 2006. In an effort to reduce the early origins of chronic disease, researchers from the University of Newcastle commenced a study in 2007 to understand health issues that affected pregnancy outcomes for Aboriginal women. Located in the Tamworth region of north west NSW, the study's development required long dialogue between the research team and members of the local Aboriginal community, Aboriginal health service providers, mainstream health service providers, Aboriginal Elders groups, as well key Aboriginal organisations including the Aboriginal Education Consultative Groups and local land councils.

Through the dialogue it became apparent that Elders of the community felt that the young women of the area were lacking in health education through their pregnancy. While the Elders were mostly happy with antenatal care, they felt that the young women were afraid to ask questions of their midwives and doctors, and that the doctors and midwives had little insight into the problems these women faced in their daily lives. The Elders were worried for young women who moved to the region with no older family members to guide them and wondered how these women would bring culture into their young families.

To address this problem, the research team began as one non-Indigenous postdoctoral fellow with a background in biomedical science and reproductive research. After seven years, this program is now known as the Gomeroi gaayngggal program, meaning "babies from the Gomeroi lands". It is now co-ordinated by me, that original researcher, now program coordinator (and the chapter's "text" voice), an Indigenous research coordinator, Loretta (and the chapter's "quotation" voice), two Indigenous community project officers (Megan and Stella), two Indigenous artists (Aunty Pearl and Trici), one non-Indigenous artistic mentor (Susan), together with a

J. Higgs et al. (Eds.), Health Practice Relationships, 153–160.

small number of on-site administrative support staff, an ultrasonographer and other laboratory research staff. The offsite team of chief investigators contribute their expertise in the areas of renal health, reproductive medicine, nutrition, Indigenous health, diabetes and psychosocial stress.

SETTING THE SCENE: THE AUSTRALIAN INDIGENOUS COMMUNITY

Indigenous communities have had a long history of mistreatment at the hands of the European community since European settlement of Australia in 1788. Although some of the earlier wrong-doings by settlers have been rectified, many have been overlooked and still cause grief and suffering to Indigenous communities across the country. Each Indigenous community considers itself to be a part of the collective Indigenous peoples of the Australian landscape, but primarily considers that its community is a unique group with distinct land boundaries, practices, language and stories.

While, sadly, cultural practices are being lost in some regions, older members in many communities are committed to sharing their knowledge with younger generations. The older members of a community are known as the "Elders" and they take their role as cultural custodians of their communities very seriously. Unfortunately, however, due to the shortened life expectancy of Indigenous people, there are very few Elders to provide guidance to younger community members.

Across Australia there are some 200 Indigenous tribal groups and as many distinctly different languages and dialects spoken (see Figure 18.1). Each tribal group has unique beliefs and traditions but there are strong areas of commonality, particularly in relation to having a deep connection with the land and totems for all Indigenous peoples. Of great importance to Indigenous culture is the rich connection to community. Indigenous families are extremely large and interconnected. Unlike non-Indigenous families, there is no distinction between siblings and step-siblings or first and second cousins, or parent and step-parent. Once someone is recognised as a family member they become completely encompassed within the family.

> Me and my partner have been together for nearly 20 years but we will never get married (laughing) – we have over 50 cousins on one side of the family! How would we ever afford to have a wedding for all the family – need to run away instead (still laughing). (Loretta)

For Indigenous people, health is seen as a holistic entity, encompassing physical, cultural, social and emotional wellbeing of individuals, with the wellbeing of the collective community being a particularly important part of an individual's health. For an individual to feel healthy, all these aspects need to be functioning in a connected capacity.

> If someone is sick you just forget about everything else in your own life and just think about them. You forget about work, your health, court – other commitments mean nothing. (Loretta)

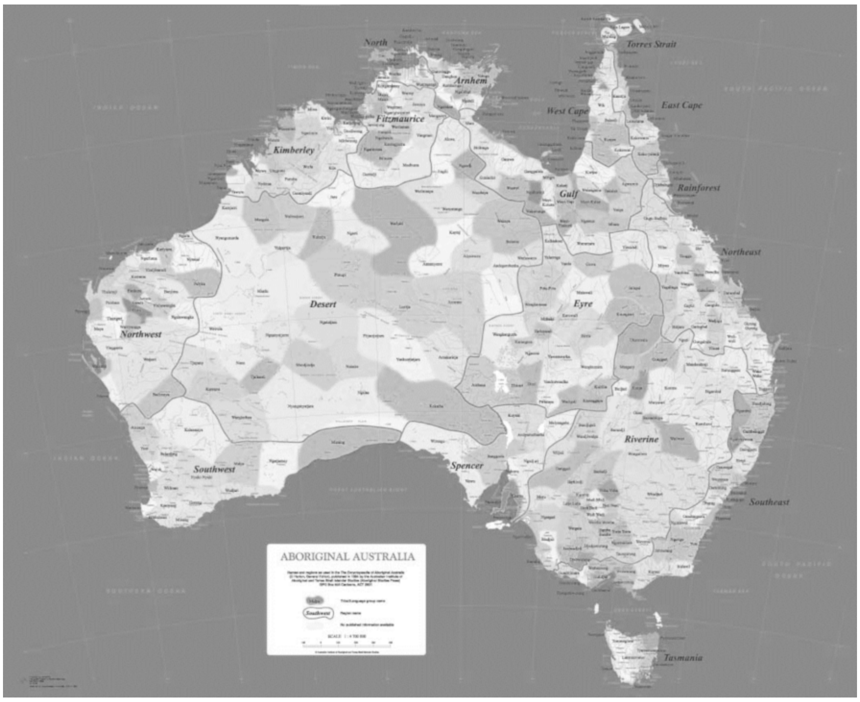

Figure 18.1. Map of Australia with Aboriginal communities/land areas defined (Horton, 1996)

The highly interconnected Aboriginal community, together with the community burden of chronic disease and ill health, has meant that Aboriginal staff of the Gomeroi gaaynggal Centre have a particularly high level of grief and loss in their personal lives. The staff of the program have worked together during times of family burdens, personal losses, through high levels of day-to-day stress, including when my own health challenges necessitated the use of a wheelchair. We all have our own challenges in life, and the open and supportive relationships that occur at the Centre have allowed each individual to flourish, something that has been witnessed by the Aboriginal community members connected to the program and the Centre. We share an incredibly close and supportive relationship that embraces our vulnerabilities. On occasions we introduce ourselves as the “cripple and the black chicks”. This always elicits a few laughs and has the effect of breaking down many barriers in a community meeting.

> We are all committed both professionally and personally – we always step in and take on someone’s load if needed. We all want to get the job done but also want to make sure everyone is OK. (Loretta)

THE NARRATIVE: DRAWING OUR RELATIONSHIPS – TWO WORLD VIEWS

In writing this chapter it has become very clear to me that unpacking "practice relationships" in the Indigenous health arena is a challenging and thought-provoking exercise. Due to the time I spend sitting on a fence, observing and learning how my world view intersects with, but challenges and is challenged by the Aboriginal viewpoints of the staff and community, I feel I am gaining insight into practice relationships in this area. I am a scientist and would like to think that I see things in a very logical and quite structured way. Because it was so difficult to explain on paper how the Gomeroi gaaynggal program staff are connected to one another, the community we work in, and the organisations we work with, I decided to draw a diagram (Figure 18.2). I might add that it took me many tries to find a way to do this so that others might see how it all fitted together.

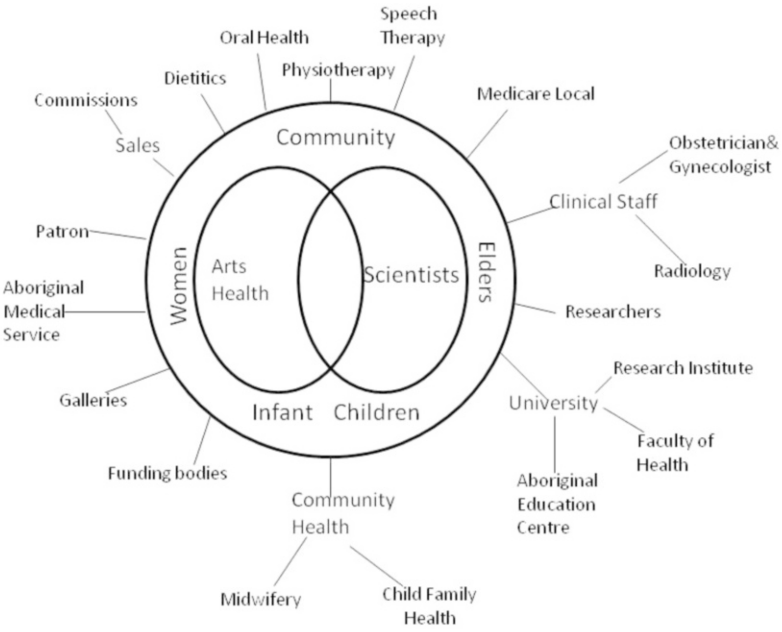

Figure 18.2. Diagram of Gomeroi gaaynggal program by Dr Kym Rae

The Gomeroi gaaynggal program is a two-armed program. The scientific arm is a longitudinal research program with women and their infants in pregnancy and in the first few years of the child's life. In aiming to understand the early origins of renal disease in Aboriginal women and their children, this arm uses biomarkers, renal ultrasounds in the clinical setting of obstetrics, and importantly, the second arm of the program, ArtsHealth. The ArtsHealth arm works with Aboriginal women, their children and other members of the Aboriginal community. This arm was developed with the Elders. It uses a strengths-based cultural and creative approach to improve health knowledge, educate health professionals, encourage artistic talent and provide a positive learning experience. Women work under the cultural guidance of our artists and resident Elder, Aunty Pearl. The work of the Gomeroi gaaynggal team in Aboriginal research, health promotion, the alignment with a variety of health professionals in clinical situations and the partnerships with Aboriginal community members gives our team a multifaceted perspective about the types of health practice relationships occurring in the unique context of Indigenous health. I see our program as sitting within the Aboriginal community, but being supported by a large range of experts in health, arts, and science. We have some staff that sit distinctly within the ArtsHealth program (Aboriginal artists and Arts mentor). Other staff/team members work only within the science research program and are often very remote from the community. Others, like me, Loretta, Megan and Stella sit somewhere between the two; we can be organising an art exhibition one day and analysing data the next.

After pondering my diagram for a few weeks, Loretta reminded me of the painting "Gomeroi gaaynggal" done by Aunty Pearl a number of years ago. The difference between these two paintings shows the distinctly different priorities we each hold: I, with the Westernised, non-Indigenous perspective and Aunty Pearl with her world view of community as the central tenet. She painted the story of the program rather than the organisational roles that people had. For Aunty Pearl the important part of the story is how the people fit into her community.

This three panelled triptych (shown as a black and white reproduction in Figure 18.3) uses a number of symbols in its work. The symbol for women is a semi-circle that reflects the marks a women makes sitting in the sand with crossed legs. A man is the same shape but with a short straight line to the right-hand side showing where his spear would leave its mark beside him. A community, shown by the circle within a circle, represents a group around a central fire together. This work shows three distinct but interlinked communities, connected by white dots that represent the Elders' past.

We had all watched this artwork being developed by Aunty Pearl over a long period of weeks, beginning from the central panel. The left-hand panel is a community of the mothers of the Gomeroi gaaynggal program who were attending at the time, many of whom are still attending and have had further pregnancies with us. The right-hand panel is the babies of the program and you can see both boys and girls in the image. At the time of painting, Aunty Pearl could tell you the name of each infant.

Aunty Pearl told us that the central panel was "us", the Gomeroi gaaynggal supporters. Note that I have used the term supporters rather than staff or team. For Aunty Pearl could name each of these people; some were health service staff, some were Elders, while others were our staff and Aboriginal women who were attendees. The large woman and man in the central panel were me and a more senior scientist who was my supervisor. Aunty Pearl referred to us both as the "big people". We had seen this artwork evolve in shapes and colours over a long period of time. The symbols representing the big people had initially been white to show that we were non-Indigenous. I can still recall arriving into work one morning before everyone else and seeing the painting finally complete and myself now painted black. When I asked Aunty Pearl about this, she told me, "*it was time you was a blackfella*". I can think about this artwork and still be moved to tears when I remember the moment when Aunty Pearl said that to me.

I think consideration of my diagram then Aunty Pearl's painting allows us to begin to unpack how different health relationships can be in an Indigenous health setting. Indigenous relationships are not straight lines but circular, coloured and deeply layered. They have texture that can only be seen up close as with an artwork, and they have the power to deeply move one's personal world view.

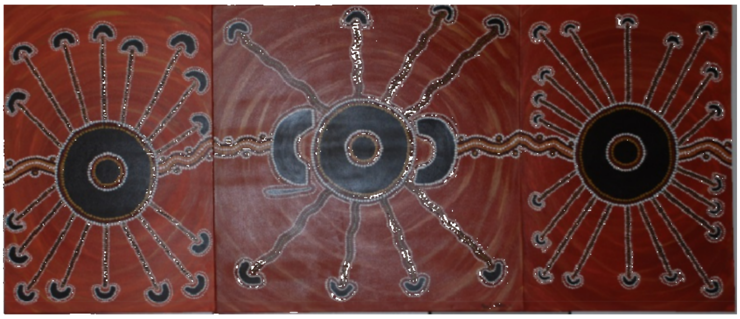

Figure 18.3. Gomeroi gaaynggal by Aboriginal artist Aunty Pearl Slater

"How Did I Get to Be Painted as 'a Blackfella' in this Program?" (Kym)

The Gomeroi gaaynggal program was developed through long conversations at a large number of levels within the community. From thinking about these conversations in relation to practice relationships there are a number of stories that we can use to help illustrate our unique setting. In the very beginning I was "working blind", that is, without the Aboriginal team members. Thankfully, I was given the vital advice that I needed to meet many Aboriginal community members prior to any research plan, grant or ethics applications being formulated. Through this process my first stop was the local Aboriginal Medical Service (a community controlled medical service). Using a snowballing referral approach, I spent 2 years meeting community members at a local, regional and state level to gauge their thoughts on how to improve outcomes for Aboriginal women and their infants. As these conversations developed, many of the areas that the Aboriginal communities felt were highly relevant to the research design became a part of the final research project and have subsequently been funded. And many of these people or organisations have gone on to become working partners, advisers and collaborators of the program. However, this is not always the case.

Research has many negative connotations for Aboriginal people, and a number of Aboriginal people within the community have been opposed and remain opposed to research. While this can be true of all communities, whether or Aboriginal or not, within a community as highly connected as an Aboriginal community one person can create enormous conflict or hurt to others.

> The participants themselves will always get the choice to say no [about being involved] and they have no problems saying it. I am the one recruiting them so I know this is true. But it is the other parts of the community that can make things

> hard. This is a tough thing to talk about – we know that there are people, not many mind you, that go around and say negative things about what you do. They say things about the research and they don't even know about it. They have never met me or asked about what I do but they say stupid things. They can be really damaging to recruitment and the hard work we do. It is really hurtful – I am doing my best for my Aboriginal people so it is awful to have someone saying negative things about what our program is doing. I just wish they would come and talk to us about it rather than just saying that all research is bad. As if I would be doing something that would hurt my own community. (Loretta)

When discussing Gomeroi gaaynggal participants it must be understood that participants are generally women who are participating in the Gomeroi gaaynggal research study. These women donate blood, urine and saliva samples, complete surveys, and have foetal ultrasounds once in each trimester of their pregnancy. They work with the Aboriginal members of the research team (Loretta, Megan and Stella) who manage their appointments, reminders, transport, sample collections, survey information, and assist with connecting them to clinical services when required. The Aboriginal community is a closely connected and caring one, and within a very short time these women often have social connections with the team. As such, connections are created where the program did not anticipate there would be one. For example, the Gomeroi gaaynggal team generally hear via Facebook that a participant is in labour rather than via the clinical staff of the maternity unit. Our participants have requested that our staff come to them in the labour ward. They come to the Centre to show off their babies when they deliver, and actively promote the research study to their friends and family members.

> One of our participants had a bubby early with a few issues – I felt so proud when she had on her Facebook page that she couldn't have visitors but she rang and asked us to go and visit her and the bub. Some mums have said that they feel like our team are the only ones that really listen to them and care about what is happening in their lives. I just like it how they come back and recommend us to new participants. It really means a lot. They have faith in us and what we are doing. (Loretta)

Over time, despite not having Aboriginal origins, I, have developed incredibly strong protective instincts for the vulnerabilities of these local communities. It is well established that Aboriginal people have often been misunderstood and misrepresented in the public eye, and that there are people who are blatantly racist and derogatory. At times, I have both passively and actively discouraged certain research groups from visiting the Gomeroi gaaynggal Centre or being involved in any aspects of the work from the Gomeroi gaaynggal programs. The reasons for this are twofold. Firstly, neither the Aboriginal team members nor the community members who participate in programs should ever have to suffer the effects of racism in the Centre, which is essentially a community place. Secondly, a lack of understanding of culture can lead to a misrepresentation of community knowledge as well as a misrepresentation of data obtained in research studies. When community consultation allows a project to move forward, the Aboriginal community are trusting the research team with their information. Any misrepresentation is an absolute breach of trust to the community.

REFLECTIONS

While I feel incredibly protective of the local Aboriginal community, as the "cripple" of the group I feel quite protected by it too. I have often experienced kindness and generosity from people within the community, as well as getting a sense of their innate sadness at my physical challenges. The Elders often kiss and cuddle me the way my own grandparents would have, and offer their own wisdom about how to face life in a wheelchair. As a minority group, the Aboriginal people recognise that I am likewise now facing life as a minority, a "disabled" person, and through their humorous approach I have learned much about how to handle discrimination that occurs on a daily basis. I never knew how challenging and disheartening that can be until I was in this position myself.

The power we see in the Gomeroi gaaynggal program is from a number of juxtapositions that can occur within a community. That is, there is deep poverty but cultural richness, a long history and a view to the future, scientific analysis and creative strength, a turning from illness to searching for wellness, a sense of giving and receiving and being protected while protecting, as well as the experience of being inclusive and being included. It has become increasingly obvious to the team that in order to connect, people must share their stories. That is, connectedness is forged and created through sharing our vulnerabilities. It seems strange, but by sharing our weaknesses we become stronger. Each team member has enormous strengths and capacity but it is through a collaborative exchange of knowledge, passions, culture and empathy that we have become a stronger collective than we can be as a group of individuals.

REFERENCE

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19. HEALTH EDUCATION AND PRACTICE RELATIONSHIPS IN A RURAL CONTEXT

This chapter is based on the story of the establishment and growth of The University of Newcastle Department of Rural Health. It deals with the relationships with the tertiary education sector, the health service sector and the wider community in the development of a sustainable model of health professional education, research and community engagement. Achieving the strategic goals of the UoNDRH has required broad collaboration between organisations and across various sectors. Both positive and negative aspects of collaboration are represented, with the intention that this might inform the future development of similar collaborative ventures through the lessons learned. The key ingredient in the partnerships that have developed is recognition in contracts and agreements of the importance of mutuality and reciprocity, as well as the independence and autonomy of the partners.

SETTING THE SCENE

The University of Newcastle, Department of Rural Health (UoNDRH) is part of a national rural health education and research infrastructure that includes the 11 University Department of Rural Health (UDRH) programs (Australian Government, 2013a) and 17 Rural Clinical Training and Support (RCTS) programs (Australian Government, 2013b). The focus of the UDRHs is primarily on supporting students and practitioners in medicine, nursing and allied health, whereas RCTS programs are focused only on medicine. Not all UDRHs are co-located with an RCTS program like the UoNDRH, but all are funded by the Australian Government Department of Health and Ageing and each is linked to one or more major metropolitan university. The UoNDRH is part of the multidisciplinary Faculty of Health and Medicine at the University of Newcastle.

The funding for each UDRH and RCTS program flows via the main campus of the stakeholder universities as a separate funding stream. In order to retain their fixed amount of funding all UDRH and RCTS programs must report annually to the Department of Health against key performance indicators (KPIs). While UDRHs and RCTS programs have a different set of KPIs against which to report, there are strong commonalities, as both are part of the overarching Rural Health Multidisciplinary Training (RHMT) Program (Australian Government, 2013a, b), the objectives of which can be summarised as:

- To support high-quality educational experiences in rural and remote areas for students in medicine, nursing and allied health disciplines

J. Higgs et al. (Eds.), Health Practice Relationships, 161–170.

- To develop university infrastructure and academic capital in rural communities with a view to improving recruitment and retention of health professionals and encouraging local young people to pursue a rural career in health
- To create opportunities for rural health and workforce research, advocate for improvements in rural health and raise awareness of rural and remote health issues, including Indigenous health.

These Australian Government funded programs have been motivated and have evolved because the health outcomes of the 30% or more of the Australian population that live in regional, rural and remote areas are measurably worse than for the urban population (AIHW, 2008). Compounding these poorer health outcomes is the fact that there is a chronic shortage of health professionals in non-metropolitan areas to serve this health disadvantaged population (AIHW, 2013). Without intervention, this gap is predicted to widen over the next 10, 20 or 50 years when, due to unprecedented aging, a greater proportion of the population will need healthcare. The UDRH and RTCS programs are part of the solution to the problem of recruiting and retaining a rural health professional workforce for the future.

The UoNDRH occupies a region that is about 20% of the land area of the state of New South Wales (NSW). It stretches from the fertile Upper Hunter Valley and Liverpool Plains in the south, west onto the North West Slopes and Plains district and north to the New England Tablelands. To the east, an arm stretches down into the Lower Mid-North Coast to include the Manning Valley and Great Lakes, north of Newcastle. Education facilities and staff are located in the main regional centres of Tamworth, Armidale, Moree and Taree, and most UoNDRH activities are focused in these hubs; however, as many as a dozen other smaller communities with health service facilities host students on placement in the region. The total population of the region is about 200,000 (NSW Government, 2013).

The UoNDRH employs academic staff in medicine, nursing, occupational therapy, diagnostic radiography, physiotherapy, speech pathology, nutrition and dietetics, pharmacy, mental health and Indigenous health, as well as a professional administrative support team and a community engagement team. As well, the organisation has received infrastructure grants to build a large education centre at Tamworth, the main hub, and a smaller, though substantial, education centre at Taree. Both are in close proximity to the local rural referral hospital, and both contain well-equipped clinical simulation laboratories, as well as lecture theatres, seminar, tutorial and meeting rooms, library space and a computer lab. The smaller hubs of Armidale and Moree have less extensive facilities and support fewer students. Subsidised student accommodation is provided at all four hubs, such that a total of 180 students can be accommodated at any one time across the region.

The UoNDRH aims to provide high-quality rural health education, support the local clinical workforce and promote Indigenous and community health. Co-location of the UDRH and RCTS has permitted the development of shared, community-oriented goals, particularly in supporting students from the various disciplines to meet their educational objectives in regional and rural locations, while encouraging their engagement with the local community in activities that promote better health and healthcare.

THE NARRATIVE(S)

The UoNDRH became operational in 2002, initially as a UDRH, with a much smaller budget than it has currently and with much smaller numbers of staff and students. The RCTS funding came later, in 2006. Over the decade or more that it has existed, it has been commonly acknowledged, most often by UoNDRH staff members, that there is a need to balance the priorities of a variety of "masters". Not least of these is the Department of Health, the funding body; however, others can be broadly categorised as:

- the tertiary education providers and their students who come to the UoNDRH region
- the local public and private health service providers whom we rely on to provide student placements, and
- the community in general, the consumers in the healthcare system, without whom there would be no need for the UoNDRH to exist.

With each there is need to have a particular relationship. So, while the overall narrative in this chapter is about the growth and development of the UoNDRH, it has been broken down into three "sub-narratives" that reflect the nature of the collaborative relationships as they have evolved.

Collaboration within the Tertiary Education Sector

The University of Newcastle offers undergraduate programs in 16 different health professions. The University of New England, with its main campus at Armidale, shares subsidiary agreements with Newcastle, most notably in relation to the delivery of the Joint Medical Program (JMP) collaboratively between the two universities, incorporating the RCTS program.[i] The JMP is required to have at least 25% of the students spend at least one year at the RCTS. Moreover, final year students in the nutrition and dietetics, diagnostic radiography and physiotherapy programs from the University of Newcastle can volunteer to spend a full year in the UoNDRH. Having students in these disciplines on-site throughout both semesters, as well as students from a number of other disciplines who spend weeks at a time on placement in the region, makes fertile ground for interprofessional education (IPE).

Few practitioners within the tertiary education or healthcare sectors would not have heard of IPE in the context of improving the delivery of healthcare. In the pre-licensure context, it is about students from different disciplines learning together for part of their training so that they better understand how to work together after they graduate (Barr, Koppel, Reeves, Hammick, & Freeth, 2005). It is intended to develop the students' appreciation of the importance of working and communicating effectively as members of a healthcare team. Targeted outcomes include safer, more patient-centred healthcare.

In 2002, when the UDRH was first established, IPE did not have the profile it does today. Although more established in the United Kingdom, Canada and Scandinavia, in Australia at that time attempts to integrate IPE into mainstream health professional education was at a much earlier stage of development. Much of the IPE being delivered then was voluntary and not assessable; and most remains so even today, regrettably. The idea of horizontally integrating health professional education for part of the students' learning challenges traditional educational models. Although the potential long-term outcomes are generally considered laudable, the barriers associated with space, timetabling and resources are common (Gilbert, 2005).

The UoNDRH delivered its first interprofessional learning (IPL) module in 2001, even before the contract had been signed with the Australian Government. From then on, at least one IPL module has been delivered each year, and since 2009 modules have been delivered on a monthly basis for those periods when students are in the region, for up to ten modules a year. Each module runs for half a day and the students' attendance is voluntary. Students from a wide range of different health professional backgrounds have the opportunity to work together in a problem-based learning format. Topics include clinical error, hip fractures, diabetes, stroke, major trauma and chronic pain, to name a few.

The number of students attending UoNDRH IPL modules each year has steadily increased from 10 in 2001 to 337 in 2012, with attendance ranging from about 20 to 50 students per module. Multiple sources of feedback from students, peers and staff provide evidence that the program enhances student learning on clinical placements and provides students with broad interprofessional experiences. The response from the students is almost universally positive, with common responses on evaluation forms being questions like "Why didn't we have this earlier in our course?" or "Can we have more of these experiences?" It is apparent that the students enjoy learning with, from and about each other.

Yet, after 10 years of persistent delivery, these IPL modules remain a voluntary activity for students on rural placement and they are not assessable within any of the university's programs. The primary reasons for what appears to be a fundamental disconnect is that although the UoNDRH and the main campus share students, the UoNDRH does not own those students or dictate the curriculum they study. The program convenors based on the main campus are supportive of the UoNDRH offering students voluntary, informal IPE opportunities but it remains at the periphery of their educational experiences.

There is a sound argument that interprofessional practice has particular value in rural and remote healthcare settings, where human resources are limited and practitioners may be isolated from their professional peers, opening opportunities for greater teamwork and appreciation of each other's roles (McNair, Brown, Stone, & Sims, 2001; Smith et al., 2007). With so many different undergraduate health professional programs, the University of Newcastle seems ideally placed to develop IPE, and the establishment of the UoNDRH was perceived by some as an opportunity to do this, avoiding traditional barriers of time and space. Students from different professions would be in the same place, often at the same time.

While this created the impetus for IPE, being rural also permitted academics on the main campus to distance themselves from IPE delivery. Some became openly sceptical, and so another barrier to IPE became apparent, the lack of will on the part of the faculty and university to engage with what seemed an exciting, if challenging opportunity. Only recently has the faculty re-examined the possibility of delivering IPE as a compulsory element of all undergraduate health degrees.

Collaborating with the Health Service Sector

At the outset, the university, and the local public healthcare provider, Hunter New England Local Health District, entered into an agreement whereby the UoNDRH staff can work in the local public hospitals to provide services to patients, even though they are employed solely by the university. This created the opportunity for unique jobs to develop, with UoNDRH academic staff members having a mixture of teaching, clinical practice and research in their duty statements (Smith, Brown, & Cooper 2009). Such jobs are not unique in medicine (Frank et al., 1996), where the tradition of clinicians teaching the next generation of their profession is as old as the profession itself, but in the newer allied health professions positions such as these have traditionally been rare, especially in regional and rural locations.

All UoNDRH allied health academics have a clinical role, most commonly in the public healthcare system, although some work in the private sector. Some of the foundation academic staff relocated from metropolitan areas to take the new positions, transferring academic resources from the city to the country. More recently, however, academics have been recruited from the local clinical workforce, creating opportunities for rural allied health clinicians to expand their horizons into teaching and research. A disadvantage of these roles is that, at times, "having a foot in both camps" can create confusion about priorities and expectations both on the part of the person occupying the role and of their clinical colleagues. For example, blurring the boundaries between clinical and academic roles sometimes leads to an expectation that UoNDRH clinical-academics will always be in the hospital department when students are there, without taking into account the various demands of their academic role. Balancing time and space between the dual roles can cause stress, and so roles and role boundaries need to be clearly defined, with mutual understanding of demands and expectations by both the health service and university "masters".

Without significant human academic resources it would not be possible to deliver high-quality educational programs that aim to attract students and younger practitioners to pursue a rural career path. The ability to fill UoNDRH academic positions locally from within the clinical workforce also means that relationships between the health service and tertiary education sectors is much stronger than if teaching and research staff were "blow-ins" from the city who were likely to "blow-out" again before too long. However, because they usually have no previous academic experience, the transition from being a full-time clinician to being a clinical-academic takes time, as well as individual and organisational investment over many years. Nevertheless, it is more sustainable to recruit experienced local clinicians with local networks into academic positions than to import experienced academics with no local knowledge.

Successive Australian Governments have pursued policies aimed at increasing the rural health workforce. This has included increasing the number of undergraduate students. Consequently, the number of allied health student placements around the country is projected to grow (Health Workforce Australia, 2011). This places increasing pressure on the public healthcare system to provide clinical education opportunities, and greatly increases expectations to provide clinical supervision of students in the workplace. However, unless the number of health professional positions increases at the same dynamic rate, the student-to-supervisor ratio will increase and risk the quality of both student and supervisor experiences (Health Workforce Australia, 2010).

Because metropolitan hospitals have been virtually saturated with student placements, universities have increasingly sought to place students in regional and rural hospitals, buoyed by the emphasis on growing the rural health workforce. Allied health departments in medium-size regional hospitals with 200 to 300 acute care beds have been placed under pressure by requests from different universities wanting to place their students. In 2003, 79 allied health students were placed in the UoNDRH region for 308 student-weeks. In 2012, the total number of allied health students had grown to 298 for 1658 student-weeks, a more than five-fold increase in student-weeks.

There are undoubted benefits to the health system of having a steady flow of students. Well managed, students can be an important part of the health workforce, but their increasing numbers necessitates new supervision models and relationships, such as those that have developed around the UoNDRH. The growth would not have been possible without the organisational support and concerted effort of UoNDRH and the local health service staff. Implementation of a model of allied health clinical-academic practice that cements the relationship between the health service and tertiary education sectors has been a key ingredient in making it possible.

Because the UoNDRH academics have a clinical as well as a teaching role they bridge the two sectors. An important element of this is the part they play in providing and organising continuing professional development (CPD) opportunities for their clinical colleagues through such activities as organising local journal club meetings, conducting seminars, organising conferences and supporting clinicians to perform their own research. This can be described as “pay-back” for the role the clinicians play in providing student placement opportunities. Providing local practitioners with continuing education has bonuses, first for the clinicians, obviating the need to travel to the city to access CPD opportunities, and second for the UoNDRH, being able to improve the quality of clinical supervision by including education in clinical supervision into CPD activities. Thus, students also benefit, closing the loop. Student recommendations about where to obtain high-quality educational and lifestyle experiences are extremely influential in sustaining the growth in student numbers.

Collaborating with the Community Sector

The UoNDRH undertakes to provide students with a stimulating lifestyle experience as well as a high-quality educational experience. The rationale, of course, is that if students come to a rural location and have a good experience they are most likely to take up rural practice after they graduate. However, there is a need to break down the stereotype of rural communities as being insular and boring. Indeed, it can be difficult for newcomers to integrate into small rural communities where family and social networks are often long-established and the tendency is to reject outsiders; but rural communities are also programmed to welcome budding health professionals who are likely to contribute significantly to the community's future sustainability, if they can induce them to stay. Part of the challenge for UoNDRH, therefore, is to integrate the university and its students into the broader community and to increase the students' appreciation of the potential breadth of their future health professional roles. Consequently, the UoNDRH has actively pursued a program of community engagement, which is fundamental in building social as well as academic capital.

The aim of the Community Engagement Program is to promote the perspective that health professionals have a generic potential to make communities healthy and happy. The message to students and to the rest of the community is that even though healthcare providers have particular clinical knowledge, skills and abilities that they apply in their occupational roles, they have broader roles beyond the walls of the hospital or private practice in improving the health and wellbeing of the community as a whole, which is frequently overlooked. This can be especially the case in rural communities where healthcare disadvantage is common. The potential reward for healthcare providers is that they solidify their acceptance as members of the community.

The range of community engagement activities that the students and staff of the UoNDRH can become involved in is diverse and it is only possible to refer to some examples. Participation is voluntary for the students and the concept of "volunteerism" is deliberately promoted. The longer they stay, the greater their opportunity to "step forward". Most of the activities are developed around health promotion, with increasing physical activity and improving nutrition being common themes, while others are based around promoting health careers. Many focus on school age members of the community, and others, such as the Health Pitt-Stop at the annual farm machinery exhibition, are directed at older people by providing basic health checks and health promotion information.

The Eat-Well-to-Learn-Well (EW2LW) Breakfast Club existed before the UoNDRH came along, the aim being to provide primary school age children with breakfast before beginning their day at school. The UoNDRH saw an opportunity to support the breakfast club by getting the students, especially the dietetics students, to attend. They help other volunteers prepare and serve breakfast, as well as talking to the children and to the parents who also attend about the nutritional value of the foods and how it affects behaviour and learning.

The After School Learning Centres are similar but operate at the other end of the school day, offering a range of health-related activities for primary school children. There is an emphasis on developing psychomotor skills through games and physical activity and on conveying messages to the children about their body and how to stay well. The student health professionals benefit by practising their paediatric interactional skills, which is also an important objective of the Teddy Bear Hospitals, another community engagement activity, where preschool age children have their teddy bears examined by the students. It is fun but also has potential to break down barriers when it comes to performing a clinical examination on young patients.

Although some individual members of rural communities can be suspicious of "newcomers", communities as a whole can be suspicious when a new organisation comes to town. There is a need to develop trust. This is particularly true in working with the Indigenous community, essentially because they have been so poorly treated in the past and are conditioned to ask, "What do they want?" when an institution arrives "bearing gifts". Suspicion surrounded the early days of the Gomeroi gaaynggal Indigenous Mothers and Babies Program, which began as collaborative research between the UoNDRH and the Mothers and Babies Research Centre in Newcastle. The scientific aim of the research was to investigate the relationship between lifestyle variables of pregnant Aboriginal women, including nutrition, smoking and stress levels, on foetal renal development. Measurement of biomarkers requires repeated sampling of the mother's blood and saliva and ultrasound imaging of the baby in-utero. For some, the idea of performing research on mothers and babies caused discomfort and suspicion. Difficult conversations were had as passions rose within some factions in the community, although other groups have always been highly supportive.

The Gomeroi gaaynggal program has developed into well-regarded Indigenous health research that has national links with eminent scientists and the patronage of the NSW Governor General. The hallmark of its success, other than the scientific research, is an arts-health program that operates in parallel and has built bridges with the local community. Women come to the centre to paint and sculpt with the help of local artists, including decorating plaster "belly-casts" of the pregnant women, linking the arts-health with the scientific sides of the program. It is also a source of health information for Indigenous mothers and their babies, and a place where older women in the community can share their knowledge and experience with younger mothers. Students attend the Gomeroi gaaynggal Centre, providing them with an Aboriginal cultural experience as well. (See Chapter 18.)

REFLECTIONS

The first decade or more since the establishment of the UoNDRH has seen bridges built with the parent university (or "mothership", as it is sometimes called) as well as with other universities, the local health district, numerous private healthcare providers, not to mention the local community and service organisations. The bridges have permitted the flow of ideas, knowledge, skills, attitudes and processes between individuals and organisations, as well as more tangible symbols of the relationships, such as contracts and agreements, human and physical resources and money. Consequently, teams have developed around IPE, work integrated teaching and learning, research and community engagement. The key ingredient in most of the collaborations that have developed is recognition of the value of mutuality and reciprocity. The partnerships that have developed around the UoNDRH have generally had benefits to all parties involved, even if some of the shared experiences have not always been positive.

An old proverb says that "good fences make good neighbours". In a contemporary sense, this translates into having in place sound contracts and agreements underpinning partnerships. While goodwill is to be highly valued in any relationship, its fragility is undeniable and so boundaries are best defined by legally binding contracts and agreements that leave nothing to presumption or conjecture and little to debate should things not go to plan. Agreements should acknowledge shared values, goals and strategies but also recognise the independence and autonomy of the partners.

The UoNDRH has benefited in this context from the leadership of the university mothership, which is the signatory organisation on all contracts and agreements. Although involvement of the main campus often complicates the bureaucratic processes, it adds strength and weight to contracts. Indeed, the relationship between the UoNDRH and the main university administration bears similarities to a parent-child relationship. There is little that the UoNDRH does without first seeking involvement and approval or gaining permission from the main campus, because it provides protection. Being linked to the mothership provides a sense of certainty and direction; yet at times the UoNDRH has demonstrated independence and autonomy, seeking to lead rather than follow the example of the parent. One example of this is in IPE, where in spite of the UoNDRH being an ideal environment in which to innovate in health professional education, it remains at the periphery of the university's gaze.

The rationale for the UoNDRH's existence is to address the rural health workforce shortfall, but this is not necessarily a high priority for metropolitan-based universities. They have different agendas and are driven primarily by the need to fill places on enrolment schedules. Being part of a larger organisation has great benefit, but being geographically remote from the main university campus sometimes means that UoNDRH appears to slip from university's agenda, even though there is clear alignment of strategic directions. The university, like the local health district and other organisations with which the UoNDRH works, is large and complex. Appreciating the complexity of the environment in which others work is an important aspect of learning to work together in any collaborative relationship.

Both the RTCS and UDRH programs have as their primary goal to increase or maintain student numbers. To do this, the UoNDRH must provide high-quality education experiences to students and to do that there is a need for close, supportive relationships with local health service providers. Recruiting local allied health professionals into academic positions and permitting them to work across both the health and tertiary education sectors requires mutual trust and commitment. It has increased the capacity of the clinical sector to withstand the pressures of rapid and sustained growth in student placements, but not entirely without complications.

Working across intersectoral and interprofessional boundaries requires balancing the priorities of all parties, and it is inevitable that some priorities will conflict at times. For example, health services prioritise diagnosis and treatment of patients whereas universities prioritise the need to place students for high-quality educational experiences. The two priorities do not always intersect comfortably and differing priorities are potential sources of conflict. Therefore, no matter the weight and strength of the contracts that demarcate boundaries (the fences), at times conflict or disagreements occur, usually adding further to complexity. This is where mutual goals, shared values, goodwill and trust come into play. Ultimately, what really matters is that neighbours have a commitment to share the boundary and find solutions where and when problems arise.

The importance of mutual benefit and reciprocity in the relationships between the UoNDRH and all its partners cannot be overstated. The UoNDRH gains the capacity to provide high-quality student experiences, while increased CPD opportunities help build the knowledge and skills of practitioners. This is further exemplified in the development of the Community Engagement Program and the Gomeroi gaaynggal Centre. In the case of the latter, while the scientists are permitted to collect research data from the community, they also give back to the community in a multifaceted, mutually beneficial relationship.

NOTE

[i] For more information about the JMP visit http://www.newcastle.edu.au/

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20. CARING FOR PATIENTS WHO HAVE SEXUALLY TRANSMITTED INFECTIONS

Getting the Team on Board

Caring for patients with sexually transmitted infections commonly requires a team approach while simultaneously invoking a range of moral responses. Understanding these responses is integral to recognising how, who and why someone might get on board the team. In this chapter we reflect on real-life situations from patient and health professional perspectives. The scenarios highlight a range of human responses towards three different situations. Responses such as interest, understanding, shame and fear influence health practice relationships and the decisions made about *getting the team on board*.

SETTING THE SCENE

Caring for patients who have sexually transmitted infections (STIs) is complex and, for some practitioners, can raise emotional or judgemental responses. These responses can ultimately inhibit the discourse necessary for developing health practice relationships. The scenarios in this chapter use real-life situations that Karin and Miriam have each experienced in their professional lives. The scenarios have been changed and adapted to remove any identifying material by amalgamating different stories from a number of patients. These general scenarios depict common yet unique experiences that resonate with us both in our respective professions.

The term *sexual health* incorporates a broader focus than just STIs and includes aspects of sexuality, health promotion and disease prevention. Some STIs are sexually transmitted (e.g. human immunodeficiency virus (HIV), chlamydia), whereas other infections can be transmitted via blood-to-blood contact (e.g. hepatitis B and C) through sharing injecting equipment such as needles and syringes.

Passion and compassion were two elements that drew Karin to the area of sexual health. She was shocked at the response of other health professionals and friends towards HIV and other STIs. Her journey led her from clinical practice to a public health role in the area of sexual health and the completion of a PhD exploring sexual health in rural areas. In her current role as a research academic at the University of Newcastle, Department of Rural Health, she has undertaken research in the areas of public health, primary healthcare and sexual health. Miriam Grotowski is a general practitioner (GP) with a special interest in sexual health that originated from her experiences working as a registrar as well as her overseas aid work as a volunteer. Miriam is accredited as an "s100 prescriber" (i.e. authorised to prescribe HIV medications as regulated by the "Section 100" Highly Specialised Drugs Program). She works in both private practice and in a publicly funded sexual health clinic as a Visiting Medical Officer.

J. Higgs et al. (Eds.), Health Practice Relationships, 171–178.

We have worked together at various times and in various forms in the area of sexual health for over two decades. In that time we have developed a level of comfort and understanding about how to negotiate relationships with health professionals and those outside the health sector. That is not to say we are complacent. On the contrary, we are open to new experiences and are constantly mindful that forging new relationships with other professionals is important for our practice. We are also aware that working in this area can lead others to label us as different, with some interactions exposing an underlying degree of discomfort with the area of sexual health. For instance, when we disclose our area of work, some other professionals respond, "I don't know how you can do it", and then go on to talk about safer and more comfortable issues.

Many people find talking about sexual health issues in an open and comfortable manner embarrassing and difficult (Ross et al., 2000). Underpinning the discomfort and negativity are a person's beliefs, opinions and ideals. As a professional, these are important issues to consider, especially in relation to how they might affect your approach to team situations when you are caring for a patient who has a sexual health issue. Given the prevalence of STIs including chlamydia, gonorrhoea, syphilis and HIV (World Health Organization, 2013) it is likely that health practitioners will be involved in the care of a patient with an STI in some way, and in doing so may be involved with a number of organisations and professionals. Getting the team on board can be a complex process. Our focus in this chapter is to reflect on how, who and why practitioners, patients and community should get on board the team.

GETTING THE TEAM ON BOARD

In this section, we use three scenarios constructed from patients' perspectives to illustrate the complexities of getting the team on board to care for patients with STIs. These scenarios provide opportunities to consider questions such as "Does everyone involved want to get on board with the team?", "If so, how do they get on board?", "Who needs to be on board?" and "Why should they?"

Scenario 1: From the Patient's Perspective, "How Can I Get You on Board with Me?"

> I am a 20 year old man. I work at the local rural hospital so I have a little knowledge of medical issues. I have had a few sexual partners but I do not sleep around. I got chlamydia from a casual partner during a one-night stand. We had used a condom together while having sex, but it split. I thought I could trust him. I had known him at school so I thought he was "clean". I knew his brother and father a lot more than I knew him so I know the family he came from. Safe sex is a big thing for me so I am always very careful. I intend to be even more cautious when I sleep with someone now. In a sexual situation, it really is impossible to know for sure whom to trust.
>
> At first I didn't realise I had caught anything. It was some time later that I thought I'd better get checked for an STI. When you go to the toilet and you see the posters on the back of the toilet door, you think, "Oh I should go and get

> checked", but then it's just a matter of working full time and having the time to get there. I know I needed that little bit of a nudge from my friends. They told me I have to look after myself and so that's what really urged me to go and do it. I went to see my usual doctor. I like and trust him. When he told me I had chlamydia I was really upset and angry. I thought I knew my casual partner and was very surprised that he was not more aware about his own sexual health.
>
> But things got even more complicated. My doctor told me I had to tell "her" that I had chlamydia so "she" could get treated and not pass it onto someone else. It got really awkward then. If my doctor had not been an understanding person, it would have been difficult to explain my situation so I would have just nodded. As it was I took a deep breath, gathered my courage and told my doctor that I slept with men. I then even explained the term MSM (men who have sex with men). The doctor seemed to understand what I was telling him and he apologised for making an assumption. I was given some antibiotics and asked to return in 3 months.
>
> It was not easy to tell my casual partner to get himself checked out for chlamydia. He is currently in a relationship with a girl who doesn't want to have sex before marriage. He was worried about her finding out. We live in a small town so if anyone found out about us it would get around like wildfire.

For the patient to get on board the team, he needed to be brave enough to deal with the GP's potentially judgemental attitudes. The patient trusted the GP and felt comfortable discussing intimate matters. In support of this, the GP was open, understanding and interested in what the patient was telling him. The patient needed the GP on board to receive appropriate care and to feel accepted and supported.

The patient in this scenario is an empowered and educated person who has a trusting relationship with his GP. However, the GP assumed that the patient's partner was female. Assumptions made by health providers about patients' sexual identity and subsequently their sexual behaviours can influence an individual's decision to disclose about sexual behaviours. Discomfort when talking to others about sexual concerns can discourage both patients and doctors from broaching the subject and can lead to incorrect judgements and misguided advice.

Reflective Questions to Consider

For the health practitioner
- What assumptions and values about sexuality and sexual behaviours do you bring to consultations?
- How might your response affect your decisions and health practice relationships?

For the patient
- How would you respond in the situation in Scenario 1?
- Would you disclose to your doctor about your sexual practices?

Scenario 2: From the Patient's Perspective, "Do They Want Me on the Team?"

> I am nearing 30 years, female, and have been using [drugs] since I was 14. Some of my friends and others I know have died over the years due to an overdose, AIDS or liver disease from hepatitis C. I know about the health risks of sharing needles and I want to make sure I use new needles and syringes when I inject. To get new needles and syringes I need to go to the local rural hospital, which is about 15 km. away. As I don't drive I have to rely on my friends to take me there. They pull up outside the front of emergency and wait while I run in to get the "needles". The hospital is closer than other places such as the community centre or the vending machine but getting needles there is not necessarily easy.
>
> I have to wait until the health workers have finished with the person before me. I hate having to wait. I don't want to hang around because I am worried my friends will just drive off and I will miss out on my share of the "hit". I also hate having to ask staff for needles at the counter because they look down on me and ask too many questions. If I ask for lots of needles they growl at me. But I know if there aren't enough needles to go around, we might have to share. I don't want to share but there might be no other option. I will have to come back for more or go to another outlet. Also I don't like the video surveillance that they have outside the emergency department. I am worried someone might recognise me and tell my family so I usually try to cover my face when I go.
>
> Yesterday I read in the paper that the council was considering closing down one of the places that I frequently use to get needles because of some complaints. I felt put down and angry that we aren't considered valuable community members. I pay rates so I think I am entitled to the services that others get. Shouldn't the council look after everyone? I offered to meet privately with a couple of people from the council and give my point of view but I haven't heard back from them. I'm not sure they even want to hear from me. When I had a health check at the sexual health clinic I told one of the staff members there who I know is on my side. They were going to contact the council to find out what was going on.

The above scenario portrays a patient who is used to keeping her drug use "under the radar" because of the social unacceptability of her behaviour. She feels demeaned by the staff at the hospital, is fearful of being shunned by her family and is silenced by the local council. Appropriate services should exist in an environment where people's human rights are respected and they are not abused or punished when attempting to access services. From our point of view, it is particularly important to engage people who may be vulnerable or may feel disempowered through their invisibility by giving them a voice to contribute to concerns. Giving voice to and supporting the involvement of a person who injects drugs requires an understanding of public health implications as well as sensitivity to and respect for others' moral judgements. The voices of people who inject drugs provide valuable input, knowledge and skills into the issues associated with drug use and they should be included as partners in addressing any concerns.

Action and advocacy by a broad range of people and organisations such as health professionals, public health, police and council members on behalf of people who inject drugs can help prevent HIV and other blood borne infections and can also reduce stigma and discrimination in health and community settings. This team can advocate and lobby for political and other policies, as well as for services that support access to sterile needles and syringes in the local area. As well as being advocates, this team can play valuable roles in educating communities about the benefits of a public health approach to STIs.

Reflective Questions to Consider

For health practitioners and others

- Do you think people's actions determine their worthiness?
- Do you have any concerns about working in the area of STIs?
- What are your feelings towards the needle syringe program?
- How would you go about giving sterile syringes to people who use drugs?
- How would you support and provide advocacy for vulnerable and disempowered people?
- How might that differ according to your comfort in dealing with different issues?
- How open are you to other points of view?

Scenario 3: From the Patient's Perspective, "You Are Getting Others on Board but Am I (the patient) on Board the Team?"

> I am a 40 year old Aboriginal male and have been shooting heroin since the age of 20. I was diagnosed with HIV infection about 12 months ago. Most of the time for the last 20 years I've felt exhausted and numb. I'm not much use to anyone and don't want to go out and socialise with anyone. I can't sleep, have poor memory and can't focus on anything. My doctor told me that I have depression. I'm supposed to take medication for it but most of the time I couldn't be bothered because it doesn't make any difference. Alcohol makes me feel better so I usually drink every night. It helps me get to sleep.
>
> I had been getting sick regularly but didn't take much notice because I usually got better. I went to see my doctor because this time I had been sick for nearly 2 weeks and I was feeling tired most of time. I thought I might have the flu. The doctor ran some tests and told me to come back in few days for the results. When the doctor told me I had HIV infection, she said I was very sick and needed to start treatment immediately. She looked a bit distressed and left the room to do something else.
>
> I was left alone. I just stared at the wall for a while not seeing anything. I felt a sickening feeling. I didn't care what happened to me at that moment. When the doctor came back, I told her to do whatever she thought was the best. I didn't care. She said I had to tell my partner. I wish I hadn't told my partner because my partner told someone else about my HIV.

> I live out of town in a rural area and when I came into town to pick up my supply [of heroin] I got caught and ended up in prison. Some of the other inmates found out about my HIV and caught up with me. It wasn't pleasant. There was blood everywhere and the wardens went right off at me. Somehow, the Public Health Unit got involved. The people from public health worked with the prison doctor to test everyone who had been exposed to my blood. I don't know what will happen to me if someone else gets it from me.

In the above scenario the patient was on an emotional roller coaster of confusion, concern, helplessness and silence. The distressed GP had to try to discuss with the patient the immediacy of the situation and explain the need to get others involved because of the public health legislation that relates to HIV. STIs are considered a public health issue In Australia and there is a legislative requirement to notify certain infections to the Department of Health to prevent the spread of infection to the community. Public health actions arising from notifications are governed by concern for community safety.

The prison situation in this scenario widened the involvement to include corrective services. Thus a number of people from different sections within and outside the health system were involved in this patient's care and the care of the wider community, including Aboriginal sexual health workers, corrective services, public health officers and the GP. Involvement of the Public Health Department is necessary because of the risk of infection to a number of people. This scenario draws attention to the consequences of having choices about confidentiality and privacy taken out of the patient's hands because of the risk to the public at large. As a result, actions related to public health legislation conflict with patient-centredness. With the focus on the safety of others, the patient may be moved to the periphery rather than the centre of care. In such situations, it can be challenging to enable patients to stay on board with the rest of the team.

Reflective Questions to Consider as a Health Professional

As a health professional

- How would your moral judgements and beliefs, opinions and ideals affect your decisions?
- How would you decide who should be on the team?

As a team member (from the range of sectors involved)

- Why would you become part of a team?
- What assumptions and values would you bring to the team?
- Have you thought about how your opinions, values and ideals might affect your decisions on the team?

As a patient

- How would you react in this situation?
- In this situation, what would be your expectations as a team member?

REFLECTIONS

This chapter raises questions about responses that carry with them a person's moral assumptions and personal judgements, that consequently affect health practice relationships. This relationship between morality and health practice relationships is of concern because it can ultimately influence how, who and why people may or may not get on board the team. Together with the needs of the patient, health practitioner and community, the need to balance the requirements of public health legislation make getting the team on board a complex and challenging process. Furthermore, the implications for privacy and control of intimate details can be a concern for patients, particularly when they have no control over the personal information that is exposed.

When considering getting the team on board it might be necessary to think through the following questions. Does everyone involved want to get on board the team? If so, how do they get on board? Who needs to be on board and why should they? How does the setting affect getting the team on board? Patients want to get the team on board despite being hidden and displaced from the centre of care to the periphery. They also need acceptance. Getting the patient on board the team may require extra effort.

How to Get on Board with the Team?

How to get on board the team as a health practitioner may require extra effort and sensitivity towards your attitudes in order to understand your moral beliefs. An open and accepting attitude can help to get the patient on board the team. As practitioners, we are each comfortable talking about sexual concerns with others. Yet this raises the problem of desensitisation, because we get so used to talking about sexual issues that we forget that others may not be as comfortable. This can cause a problem when establishing relationships with other professionals. The problem of language use can create a situation where other professionals misunderstand the information, leading to shock and or distress in some way. Being aware of your underlying assumptions and language use can help patients and others get on board the team.

Who Needs to Get on Board with the Team?

Deciding who gets on board the team can involve different understandings about the issues involved as well as about who should be on the team. For instance, there may be agreement that getting others on board the team is in the best interests of a patient. The notion of "best interests of the patient" may extend to others in the community and involve the use of legislation. The Public Health Act can ultimately give permission and greater credence for practitioners to bring on board others with whom they would not normally have contact. This is especially the case with sexual health. The Public Health Act allows contact with government and non-government organisations as well as with individuals who can help direct a focus on containment of the illness or disease. However, the others you approach may not see the need or may express reluctance to be on board the team. You might need to negotiate and provide some explanations and education about myths before you can reach some shared understandings about patients' needs. Myths such as “it’s only certain people who get STIs” and “you can avoid an STI if you have anal or oral sex” and “STIs affect marginalised groups” are incorrect and warrant education to ensure that the correct information is given.

Why Would Health Practitioners Get on Board with the Team?

Reasons for health practitioners getting on board the team are varied. As shown in this chapter, advocacy, social justice, patient care, and protection of the wider community are some rationales. Patient-centred care underpins a number of these motives. However, getting the team on board when the patient is not at the centre of care can present some challenges; the motives may rely on the practitioner having a broad understanding of the problem. These challenges might relate to differences of opinion about how to manage conflicts of patient confidentiality and privacy, balanced with the need to provide care for the patient and the at-risk community. Moreover, these challenges can affect the person-centred elements of relationship, context, place and self (McCormack, 2004). Developing relationships with others will require some negotiation skills and the ability to address emerging challenges.

CONCLUSION

The complexities of getting the team on board cannot be denied. Underpinning these complexities is the social response towards STIs that can affect many relationships. Getting the team on board requires understanding, confidence, interest and compassion for the patient, as well as recognition by health practitioners of the need to consider how their own underlying assumptions might affect health practice relationships and decisions about who should be on the team.

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LYNNE ADAMSON

21. LONG-TERM MENTAL HEALTH RELATIONSHIPS

Community Mental Health

Living with mental illness is a challenge for many people and creates the need for comprehensive health and community services. Over recent decades, mental health services have transformed from institutional to community-based care, with a clear transition from custodial care to person-centred treatment and support services. Health, housing, rehabilitation and recreational services work towards supporting the least restrictive environment for people who live with mental illness. Changing work environments and models of practice have significant impacts on health relationships. The reality of community-based mental health practice is one example of complex social systems. Consistently important in any mental health service is the need for interpersonal relationships that are therapeutic and positive in their outcomes.

This chapter presents narratives that provide a glimpse of issues encountered through the diverse relationships encountered in community mental health. The experiences are drawn from a range of settings within the context of supported community living for people with mental illness. The unique part of these narratives is the link between people who access services, practitioners' roles, and the work of teams towards meeting people's life aspirations.

SETTING THE SCENE

Shayne was diagnosed with schizophrenia when she was 19, living with her mother and stepfather. She described her life as "pretty wild" then, and remembers drifting between friends' houses, late nights, drugs and alcohol. Having left school 3 years earlier, she occasionally worked to supplement her income of unemployment benefits. With no aim to look for long-term work, she needed money to buy alcohol, drugs, and a small and random supply of food. At this stage of her life, Shayne's relationships were fleeting; many people passed through her life and her family memories were not happy. When diagnosed with schizophrenia she suddenly found herself in the new scene of mental health services. She felt lost, alone and without friends or family. Reflecting many years later on her experiences with mental health services, Shayne described her contact with various staff and clients as giving her new perspectives on life and sustaining her through challenging times. Shayne's first contacts with health practitioners were in the acute ward of a local general hospital. To her, this was a scary environment: no smoking allowed and nothing to do during the day. She had no focus in life and couldn't see the need for one.

J. Higgs et al. (Eds.), Health Practice Relationships, 179–186.

> All this talk about goals and where I wanted to live and work – nothing made sense to me, why would I want this? I didn't trust anyone, I didn't want to talk, and the constant changing sea of faces around me was overwhelming, I just hid in my room for days.

After nearly 3 months in the acute hospital ward, Shayne was discharged to share a house with three others, also referred from the acute service and with similar health experiences. Shayne attended an outpatient clinic for several months before being referred to the community mental health team. For the next 4 years, Shayne attended a local living skills centre where she took part in cooking and social groups, on occasions working in the centre's kitchen for a small wage. Appointments with a drug and alcohol counsellor and an application to the state housing department were arranged by Shayne's case manager as part of the longer-term goal of independent living. Shayne found her new living arrangements and the contact with the mental health service challenging, especially when it came to forming new relationships. Over time she saw some positives emerging from the experience.

> Basically, I lost all my old friends. At first I relied on other patients, and a lot on staff. Now I have a few friends (that) I have met through living skills, we go on outings. I rely on the counsellor as my person to talk to, and sometimes I need to call on my case manager, especially when I don't have enough money, or if I feel myself heading towards hospital again. I tend to make my own decisions about the health professionals I meet. Sometimes I feel very young staff could not possibly understand me and my life, and yet sometimes they show they're interested, just by listening. I like that. I know I can be difficult, but I really do want to be treated as me, not just another patient.

Shayne's path to her link with community mental health practitioners is common: initial contact with acute hospital services, then community-based teams. Other clients do not experience hospital wards and have their first contact with community services. Relationships with health practitioners might be short-term and needed during a crisis period, whereas others develop over many years. The narratives presented in this chapter reflect the people, both clients and staff, and the situations encountered on a journey through mental health services.

COMMUNITY MENTAL HEALTH NARRATIVES

Teams: Challenges and Strengths

Community health teams vary in size and composition, but generally are made up of practitioners from several disciplines including nursing, medicine, occupational therapy, social work and psychology. Some teams use specific models of practice that shape the roles of team members, although within a team various conceptual models might operate. Most teams include a team leader who can be from any of the disciplines represented on the team. There is often a "flat" hierarchy, with shared decision making and interprofessional or generic responsibilities.

Bill, a senior nurse who previously worked in acute mental health settings initially gained his qualification within a psychiatric hospital. He described the benefit of the community setting from his perspective:

> You get to know who people really are, and I mean my co-workers as well as the clients. Even though we still know the diagnosis of clients, we concentrate more on what is important for the person.

The change Bill experienced within mental health services was the adoption of recovery-based model that focused on managing life with a mental illness, with hope for recovery, rather than a more medical orientation to disease. As Bill moved from a hospital to community-based services he noticed the difference in practice:

> Once we were caring for patients, protecting them [in hospitals] away from the "real world" and now we are assisting them to face all the highs and lows of life in the community. A recovery approach means that we want to be positive, we want to instil hope and the expectation that life can be what the person wants it to be.

As a nurse within the hospital ward, Bill's role had revolved around medications, behaviour management and being involved in ward-based treatment groups. His role in the community team included education. This involved explaining different approaches to treatment, helping clients to identify areas of life that might be difficult. He could provide information about the range of choices available so that people could make informed decisions about what might suit them, taking responsibility for planning and implementing their own treatment.

Whereas there were once "departments" or specific spaces for health professionals of different disciplines, current mental health services are usually situated in community settings that can include shop fronts, houses, or rooms within other community health services. The model of practice is often interprofessional or multidisciplinary, with roles shared between practitioners. This "generic" work can create blurring between professional boundaries, although many teams also maintain specific input and strengths from disciplines among the team members, as Bill noted:

> The boundaries between different roles sometimes have to be negotiated – we know what our discipline backgrounds are and even when we don't have that discipline label, sometimes we want to make sure that our background is recognised.

Other team members agreed. Julie, an occupational therapist, reported that when she started work, she really wanted to be that person she had spent 4 years becoming.

> At first it was difficult to sort out what I really should be doing. I felt like I had jumped in the deep end – there was no one telling me how to do my work and it all seemed a blur. How could I really contribute to the team? I was daunted by so many experienced people on the team. I was the first OT [occupational therapist] for many years, so I felt I had to prove that I was a good choice!

Chloe, a new graduate, was challenged by the need to appear professional but at the same time friendly and approachable. "I wanted to be the 'expert', but had to work out the best way to start the therapeutic bit; after all, I was there to help".

Grant, a social worker, agreed. Initially he struggled with "getting the balance right". He wanted to be friendly but realised he was "not a mate":

> I like being there for my clients, but not necessarily being relied on all the time – I'm the resources and ideas person or the one to come to on a down day. They should be able to call on me, but I have to admit, sometimes I'm so busy I can't always act immediately. That's why other relationships in the community are important. What I like is the links with other services, like the local gyms, the recreation programs and services, and even the doctors I might contact to refer a client.

An ongoing challenge in community mental health is communicating about clients. Bill noted that it was not always possible to rely on meetings to share information:

> We're on the run so much of the time, we mostly have a quick catch-up over coffee. … we do have formal team meetings, and they give structure to communication. Good notes are important too. And we have to trust each other.

This Is My Place: Group Homes

Pete lived in a group house with three other men aged between 25 and 32. All had spent time in the acute psychiatric ward of a local hospital. Each young man had his own "case manager", who visited. Pete was proud of his "own space", his bedroom adorned with sci-fi posters. At first, he was reluctant when Sue, his case manager, said she would visit him at home. He didn't mind going to her office at the centre, but he wasn't sure about having visitors at home:

> I kind of wanted to be proud about my place, but it was a bit strange at first. I said yes, and it went OK. So now, sometimes I invite her for a coffee. It seems pretty normal now. But I don't have other visitors. Mostly I go out, just hang around at the drop-in centre for a while, maybe sometimes an outing. I've thought about the art class, but haven't made it there yet. It always takes me a while to get used to a new worker, you know, to trust them, especially the personal stuff. Like, if a young woman arrives, and I want to talk about personal worries, like sex, or something. I'm not sure, and don't want to see them uneasy.

Jodie was happy in a shared house for 2 years, but then tired of the constant noise created by a new fellow tenant. She was concerned that her room was entered when she was not home, her possessions used, and generally began to feel more and more isolated. Adding to her woes was the fact that she thought someone could enter her room through a hole in the ceiling. The organisation that owned the house refused to carry out repairs, pending a decision whether or not to sell the property, creating greater stress for Jodie. She thought the case worker should be supportive and became irritated at what she saw as lack of support:

> Yeah, so OK, I wasn't homeless and was told to be grateful for a roof over my head. But at the same time I was unhappy and couldn't do anything, and I didn't have enough money to move anywhere.

Micky had lived in shared accommodation for 6 years before becoming eligible for public housing, a one-bedroom unit in a large housing complex. He liked the support of the group home, but still wanted to try being independent. Having his own space meant he had finally achieved something in life, even if it didn't measure up against the lives of his two brothers. His finances were managed by a state-appointed guardian so he knew his rent would be paid, having been evicted from two other homes in the past for not paying rent. Money management had caused difficulty in past relationships.

> It's tough. I want to be normal, but I know I just don't fit in, so why should I keep trying? I like to have somewhere to go when I feel like it. They are not judgemental, and when I feel like working, I like going to the coffee shop, I earn some money. For a while I used to ask one of the workers to lend me money. I knew she wanted to help, so she gave me money. I guess I shouldn't have done that, but it helped at the time. I kind of knew I was using the situation.

What if "My Place" Is the Street?

Being homeless was never a goal in life for Sam, but at the age of 17 she found herself "sleeping rough". Home had become a place of tense fighting; her mother was always critical, there was never enough food and her mother's friends seemed to take the sort of interest in her that she didn't like. Sam sensed voices telling her to move, to find her place somewhere else. She couldn't tell where this would be, but she felt easier if she was on the move. Establishing a relationship with her is a challenge for health workers, building trust is a long-term proposition. John took on the challenge:

> I know Sam needs her space. I don't put any pressure on. I'll wait till she's ready to talk. I'm pretty sure that will happen, given time. It's a strong message to give – being there, not judgemental, not pretending to understand but willing to listen.

Family Relationships

Lee struggled with mental illness for many years before being diagnosed with bipolar disorder.

> It was a relief really, finally after years of so many highs and lows, now I could see that it wasn't my fault. The effect on relationships was one of the worst parts of my illness, and also the thing that made me realise I had to get help. I realised I needed help when I was losing my partner and kids. I had lost so many relationships in the past, my partner, my family, so I thought "no, I mustn't let this happen again". I sat in my car outside the hospital for 2 days before I plucked up the courage to go in and seek help. I need a strong, trusting relationship with a doctor, as I am still trying to get the medication right. But I'm much calmer now. Sometimes it's a struggle to be sane. I quite like being a bit mad. It's exhausting trying to be normal. But I do it for my family. I've seen the effect on important people in my life. I want to keep my relationships going now.

Di also described finding her family relationship difficult to manage. When first diagnosed in her late teens, Di left home, drifting between friends' places until being admitted to the acute psychiatric ward of the local general hospital. She asked that her family not be told, but eventually gave in, phoning her mother to let her know where she was, although requesting her not to visit.

> I thought she was part of the problem. I should be independent. But then I found I needed her help. Then a few years later I decided again that she only complicated my life. I don't have much contact now.

Models of Practice

Relationships in mental health services are shaped by models of practice within the organisation, often within a particular discipline. Approaches to intervention impact significantly on relationships and people's roles in such services. In many community mental health services, a recovery approach sets the broad direction for services. That approach suggests that the person receiving the intervention is not a passive recipient and should be key in planning and adopting strategies to create positive outcomes.

The Clubhouse model of psychosocial rehabilitation takes an alternative approach to relationships. Unlike traditional medical services and most community service models, it actively seeks client participation and empowerment. Emanating from the consumer and self-help movements of the 1970s, the Clubhouse model is one of participation. People attending a Clubhouse are members, not patients or clients, and work in a collaborative approach with staff (ICCD, 2013). The program of a Clubhouse is arranged around a "work ordered day", drawing on interests and skills of members and staff to carry out the work of the Clubhouse for the benefit of members and the local community. Peer support is valued within many community-based programs and is a feature of Clubhouses (Coniglio & Hancock, 2012). Ted has attended a Clubhouse for 5 years and reported the strength of early relationships:

> I'd been to living skills before and didn't relate to cooking, and shopping doesn't interest me, so when I first came to Clubhouse, I was a little sceptical, but my case manager said to try. Well, I guess it was after about 8 months I realised I had been going every week, mostly 2 or 3 days, sometimes 4 days! I'm on two committees, I help run the coffee shop and most weeks we go on an outing. I've thought about the work program. But for now, I like being in the Clubhouse. That's where I feel I have something to offer. I can be a support to new people now too. Recently we started a research project with the university; we want to show the benefits of having this place.

Staff roles within a Clubhouse are very different from those of many other psychosocial rehabilitation programs. International accreditation standards require relationships to be collegial. Staff do not have a privileged position within the Clubhouse environment. Annie described the change in how she perceived her role:

> At first it was a bit of a shock… there was no staff office… we were all in the same space. I was used to writing reports, having case meetings and being the professional. In the Clubhouse, I was "one of the team". Meetings were attended by staff and members. Everyone was responsible for making sure jobs were done. But really, this suited me, I was looking for a change. I really relate to the ideals of the program.

Being a Mental Health Practitioner: A Therapeutic Alliance

Lisa is an experienced mental health practitioner, educator and researcher. A qualified OT, Lisa has worked in many roles in mental health teams. One important role was to coordinate a new employee support program, particularly for new graduates. Reflecting on the ways relationships shape practice, Lisa highlights the importance of trust and rapport. Regardless of conceptual or practice models, attending to developing relationships with clients will result in positive therapeutic outcomes. One of the first steps in being an effective mental health practitioner is self-awareness:

> How you perceive yourself translates into your behaviours within your role. If you see yourself as the "expert", the most knowledgeable within the relationship, you risk losing sight of the experience clients bring to their situation. Any attempt to assist people to take responsibility for their care might be more difficult.

Building confidence in the role can be a challenge for new graduates or students. The signs of discomfort in a role can be obvious – a nervous glance, hesitant speech, lack of confident in the information being shared. Developing a confident but not overbearing persona is important in long-term community work where clients may have experienced many practitioners over time. Active listening skills are essential to ensuring an accepting attitude and willingness to pay attention to concerns being expressed. Learning how to build empathy quickly, conveying support in a genuine, not forced manner is also crucial.

Establishing effective relationships with clients is essential for assessing the health of a client, and when "normal" emotions such as anger or depression have escalated to a situation when further assistance is required. More experienced practitioners recognise patterns in behaviour and identify when a crisis situation might be emerging. Strong relationships built over time are key to offering an effective response in urgent circumstances. Part of this relationship is establishing "ground rules" for interactions between client and practitioner. Clients may then agree that when they are unwell they will trust the therapist to make a decision on subsequent treatment, resulting in appropriate intervention as needed.

Skilled supervision and support, either from within the team or through the broader service, are key to effective mental health practice. The capacity to reflect on relationships and their role in intervention is a professional skill that often requires support for development. It is not an automatic skill acquired through education. Lisa concluded, "reflective practice complements the development of clinical reasoning skills and will make the difference between being a 'therapist' or a 'technician'".

REFLECTIONS

From these narratives, we learn that power dynamics change when a model of community living is adopted. Emerging from a traditional “medical model”, mental health practice in community settings requires re-thinking relationships that occur between those involved in long-term, complex and comprehensive community services. Adopting a person-centred and recovery approach to mental illness places a shared emphasis on decision making.

Relationships between practitioners are also challenged in community practice. The need to respond to emergencies and to prioritise the most urgent client situations can place stress on teams and diminish capacity to develop strategies for clients needing assistance with longer-term goals. Communication and trust are essential, especially when roles overlap and boundaries between disciplines are less distinct. Professional identity remains important, yet managing both formal and informal team relationships engender effective decision making. Reflective supervision, good team relations and support guard against stress and burnout.

A recent challenging issue in mental health practice is the participation of consumers or service users in research. Research in mental health services includes drug trials, evaluation of interventions, or outcome measures to determine cost-effectiveness of services. The challenge is to develop effective strategies for involving people with first-hand experiences in research that informs evidence for practice (see Wallcraft, Schrank, & Amering, 2009). Identifying signs of stress at work, burnout, or ineffective communication is essential to ensuring good intervention outcomes. Supporting students, new graduates and new team members is important for establishing a shared team culture. Attention to team dynamics and realistic support for the work of a team that recognises the significance of person-centred practice will enhance therapeutic alliances in mental health practice.

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ROBIN TURNHAM AND DIANE TASKER

22. CARE AND CONTROL IN ONGOING HEALTHCARE RELATIONSHIPS

Making Decisions for Someone Else

Providing ongoing healthcare on a daily basis tends to be admired as selfless, and difficult but critically important to the wellbeing of people in our society. Because we admire such caring work, we are often reluctant to consider the presence and influence of controlling relationships that can disadvantage or harm vulnerable people receiving healthcare. Discussion of such issues tends to be the domain of human rights rather than being embedded into healthcare practice. With the increasing need in society for community-based healthcare, tensions between care and control need to be considered and discussed. Openly acknowledging these tensions provide a foundation for practitioners and others to more mindfully consider the relationships they have with the patients and clients.

SETTING THE SCENE

The need to protect vulnerable adults and children in residential and healthcare settings is supported by the United Nation's declaration of human rights for individuals with disability (United Nations Enable, 2006). Most western governments have developed adult protection mechanisms for such protection, for example, legally appointed financial managers/administrators/trustees and/or guardians with decision-making powers in such areas as accommodation, health and provision of services. The narratives in this chapter have drawn on experiences within the adult protection space where such tensions arise as a matter of course.

NARRATIVES OF CARING AND CONTROLLING RELATIONSHIPS

Controlling relationships in healthcare are not easily or commonly discussed. It can be difficult to articulate the problem of concern or even find meaningful language to express such tensions between care and control. Healthcare practitioners, clients, families and the multiple sorts of carers who now work in both residential and community-based healthcare and the more public sphere of managed care tend to feel uncomfortable and sometimes ashamed of these dilemmas. They may be reluctant to discuss them, fearing disapproval from superiors and peers. In the interest of all concerned, these tensions in healthcare practice deserve to be openly discussed if we are to protect and promote the interests and wellbeing of more vulnerable members within our society.

J. Higgs et al. (Eds.), Health Practice Relationships, 187–194.

Narrative One: Physical Restraint in Healthcare: "For Her Own Good"

> One day, in the company of a social work student who I was supervising, I visited a woman called Gwen in an aged care facility. Gwen had a history of mental health problems (now also known in the professional discourse as psychosocial disability) but no other health problems. She had been placed there from a psychiatric hospital at a time when community-based healthcare focused more on "taking your medication" than receiving the practical support she would have needed to be able to stay at home. Gwen had no relatives or visitors.
>
> This nursing home was an old-style facility, which specialised in the care of people with long-term psychiatric disorders. There are many facilities caring for such people in our community. As we walked into the main entrance, we were directed to a dingy set of stairs leading to the second floor. Gwen was sitting in an upright vinyl lounge chair lined up against the wall along with other residents, with an attached tray table in front of her and a cup on it. I was aware that she had been a nurse for many years and wondered how she felt about being in the sort of care situation she now found herself in. She was happy to speak to us and indeed was able to communicate her needs and wishes quite well. Gwen told us she wanted to have a cigarette but that the staff would not give her one. She asked us to take the tray table away so she could get up. I knew from her records that she was well able to stand and walk and had not had any falls but as there was a cup sitting on the tray table, I presumed that she had just had her morning tea. We began to struggle to remove the tray table as Gwen had requested but it was locked in place. A nurse hurried over saying, "Don't do that". I asked why and she pointed to the stairs saying "she could fall".
>
> Even with my years of experience, I felt quite shocked. I had not realised that in our modern healthcare world, someone could still be physically restrained, supposedly "for her own good". When I was able to speak to the Director of Nursing (DON), I asked why she could not be placed in a room on the ground level to better access her environment and go outside to smoke as she wished. The director told me that it had not seemed to be much of a problem and no one had asked for her to be moved. Subsequently, I rang again and found that Gwen had been moved downstairs and the table restraint removed.

Reflections About the Use of Physical Restraint

The type of restraint seen in the above narrative could be called "covert restraint". To anyone visiting, it looked as though the tray was being used to have afternoon tea but visitors would only be able to recognise that Gwen was being physically restrained if they were present for a longer period of time and able to observe that she could not get up when she wanted to. Staff may have given a variety of seemingly legitimate reasons for imposing such restraint: their fear of Gwen falling, the need to stop her absconding or intruding into other people's rooms and belongings. The afternoon tea time ritual provided a convenient entry point into the use of restraint. Whatever the reason for its use, unauthorised physical restraint as applied in Gwen's case is an example of the offence of false imprisonment.

For Gwen, the situation presented a very unacceptable and disturbing reality; she was effectively locked into her chair against her will. She would not be able to stretch a cramped hip or go to the toilet as she needed and despite the good will of carers, she may need to wait long periods of time for assistance. The known risk factors that occur with the use of physical restraints for people in care situations can give rise to further healthcare problems for the people concerned. Incontinence aids may often be used earlier than really needed (with the side effects of loss of dignity and the other health problems that can then occur, for example pressure areas). People who are restrained and increasingly call out to staff are often then viewed as being confused or troublesome. Increased vocalisation from physically restrained people can lead to confirmation (in staff's minds) of the need for the restraint. Ironically, evidence also shows that the use of physical restraints for people requiring care can actually lead to increased levels of injury and even death if they try to escape their restrained situation (Capezuti et al., 2008). The same applies when a person is subject to chemical restraint. The use of chemical restraint to control mood and voluntary movement may also increase the risk of falls and subsequent injury. The narrative above illustrates how little power people may have to change their situation in healthcare settings. Furthermore, for the staff concerned there is a possibly learned level of insensitivity to the distress of others. This insensitivity can be exacerbated by inadequate monitoring of human rights, poor staffing levels and high turnover of minimally trained staff.

The restraint of people against their will is antithetical to the ideal of person-centred healthcare advocated by modern healthcare practitioners and expressed in the policies of care service organisations. When a client's voice is not heard and their concerns are not addressed to their satisfaction, extra care needs to be taken by others who have power to make decisions on their behalf. There is a risk that such decisions can be against the will of the client and may lead to harm. Although practitioners may try to be caring rather than controlling with their clients, incidents of such controlling relationships still occur regularly and can be difficult to identify or remedy. Collusion between staff to continue restraint may arise from poor staffing levels and the staff's need to present the appearance of a peaceful environment to visitors. Inherent in caring relationships is the potential for care to turn into control and even abuse.

Narrative Two: Abuses of Trust: Blurred Friendship Boundaries in Healthcare

Friendship is often an element of ongoing care within healthcare settings for people with disability or chronic healthcare conditions. People in these settings can be very lonely and eager to accept offers of special attention from healthcare staff. Such friendship, while laudable, can lead practitioners into difficult areas of interpersonal relationship negotiation. Such a developing situation occurred for a young nurse in a large aged care facility. Jenny began by providing much needed emotional support to an elderly man called Jim. Jim had no relatives and was very sad about the loss of his physical independence and the need to leave his home. Jenny's presence made him feel better about his situation and he encouraged her to stop and talk to him about her life and what she did each day.

Initially, in gratitude, Jim offered her gifts but Jenny gently refused them and assured Jim that such gifts were not needed or necessary and that she liked to care for him. Jim became increasingly attached to her and was upset when she had to go on holidays. Jenny was late one day and came to visit Jim in a flustered and upset emotional state. She told him that she had broken up with her boyfriend and that her car had also broken down on the way to work. She was worried that she did not have enough money to get it repaired. Jim was very concerned and wanted to help her with the costs of the repairs. Jenny again refused but he insisted that it would make him happy to help her and that he was very wealthy and would not miss a few dollars. Finally, Jenny agreed and Jim quietly pressed a cheque into her hand as she left him that day. As time went on, other situations arose for Jenny and Jim increasingly wanted to help and be involved in her family life. He had never had children of his own and this relationship made him feel happy, as he repeatedly told Jenny. Eventually Jim approached his solicitor to change his will in Jenny's favour. At this stage, the DON became involved. Jenny was interviewed and subsequently lost her job. The DON also made an application for Jim to become the subject of a financial management order under the State Guardianship Authority. Neither Jim nor Jenny felt that they had done anything wrong. Jim was very upset to lose his daily contact with Jenny although she continued to visit him from time to time as a friend.

Reflections about Blurred Friendship Boundaries

On reflection, it is clear that although Jim did not feel exploited or abused, he was definitely a vulnerable person in that relationship because Jenny could have withdrawn her visiting to him at any time. Her acceptance of increasingly valuable gifts from him contravened facility policy and was viewed as unethical behaviour for a healthcare practitioner. Professional codes of practice guide practitioners about such issues, but the reality of managing those issues from a personal point of view is not easy or simple. In practice these ethical boundaries are often blurred. As Bray (2011) advises:

> The only firm boundaries we can point to are legal boundaries – apart from that, it's all about differing needs and differing values, and because of this, there will always be a level of disagreement. (p. 1)

To reduce the risk of serious boundary breaches by healthcare workers it is now recommended (Scheiderer, 2012) that practitioners have a regular opportunities for open frank discussion about dilemmas they may have in their relationships with their clients.

Narrative Three: Controlling Relationships: Predatory Acts of "Care"

While the above narrative involved a gradual and possibly unintentional ethical concern, some presenting abuses of trust may be frankly predatory in nature and require formal referral and investigation. In a study of the experiences of care workers in the community (Turnham, 2014) a group of healthcare workers related the disturbing story of a co-worker who had made herself increasingly essential in the life of one of her clients. The client was confined to a wheelchair and terrified of being placed in residential care. This particular care worker actually moved into her client's house and persuaded her to change her will to benefit her over the woman's children in return for the undertaking that she (the care worker) would care for her at home for the rest of her life. Other controlling behaviours in this situation included undermining her self-confidence, alienating family and deliberate isolating of the woman from other people. Typically most of this behaviour by the worker occurred in privacy in the woman's home, "out of sight, out of mind". When her behaviour came to light she was taken off the agency's books but her former co-workers commented with concern that she just moved on to another care agency.

Reflections on Predatory Acts of Care

Such frankly controlling relationships are referred to in the literature as "psychological abuse" and in legal terms as "undue influence" (Quinn, 2000, p. 9). Healthcare practitioners need to be aware that any vulnerable person may be at risk of such controlling relationships developing and when necessary act swiftly to ensure the wellbeing of those vulnerable people. The predatory incident discussed above and the reluctance of other carers to talk about it demonstrates the difficulty of recognising that a care relationship can be abused so seriously.

Narrative Four: Bridges of Care: Working with/for People Needing Healthcare

In the following narrative, Fred, an older man with a history of acquired brain injury, alcoholism and homelessness had "fallen between the cracks" of his healthcare and financial management. The complexity of his healthcare problems combined with Fred's inability to engage consistently with those who might be able to help him. Carefully crafted assistance by a new case manager, Lynne, only became possible when she entered *his* world of "friends on the street" helping to create *bridges of care* between his world of living on the street and the more formal world of healthcare.

> Fred had long needed assistance with managing his financial affairs and often came into the financial management office to ask for money from his private funds. He was believed to have been living with a partner in public housing but a social worker noticed that Fred had broken his arm and was not looking well. While talking, it became apparent that Fred had been homeless for at

least 5 years and was actually living under a bridge near a large river. It also emerged that he had broken his arm in a fall into the river at night when he was drunk and unable to see properly due to severe cataracts. This was not the first time that Fred had fallen into the river late at night. The social worker made further enquiries into Fred's financial situation and found that he had received a compensation payout many years before as a result of an accident but that little of this money had been used to meet his needs.

The social worker was able to develop a plan with Fred's financial manager which included engaging a private case manager with proven experience in dealing with the complex issues of drug and alcohol addiction complicated by homelessness. The initial hurdle was how to assist that case manager to meet Fred who often did not turn up to appointments. The development of a relationship between Fred and Lynne was accomplished by offering him additional funds on a particular day of each week to establish a regular contact time. After about two months, Fred had got into the habit of coming into the office regularly on "his day of the week" and was able to meet up with his prospective case manager. This was a transparent arrangement and full discussion about it was held with Fred.

After getting to know Lynne, Fred was very happy to have her assist him to organise healthcare for his cataracts, to organise a comprehensive medical review and also to start finding him somewhere to live more safely. The key to Lynne's success for Fred related to being centred on his world, not hers. She engaged with his friends/drinking mates and an ex-partner, all of who wished Fred well and were willing to help as they could. They assisted by reminding Fred to wake up in time for health appointments and made sure that he had food and medications. They also accompanied him to his appointments. One of Fred's friends was funded to help with this process.

Fred's most important health concern was blindness, which was so severe that people had to help him cross roads. Lynne found a local doctor who accepted Fred in his perpetually inebriated state as a new patient and then negotiated with a surgeon to operate on his eyes. Fred's healthcare was accomplished with a variety of creative approaches combined with admirably flexible responses from healthcare professionals. For example, Fred required alcohol during his healthcare admission and therefore needed a local rather than a general anaesthetic. This meant that his attendant behavioural difficulties also needed to be dealt with by hospital staff during surgical procedures, no easy matter. Although they found this difficult, everyone involved in Fred's healthcare managed to continue to help him with a view to increasing his safety and quality of life. Eventually, Lynne succeeded in finding him a converted garage and negotiated with the landlord to manage ongoing concerns.

Reflections on Bridges of Care

The social worker was aware that Fred had been denied assistance by many different healthcare services based on reasons of supposed non-compliance and possibly healthcare workers' attitudes of *therapeutic nihilism*. This term refers to an attitude by healthcare practitioners that is based on a belief that it is a waste of time to assist people have drug or alcohol problems. Broader issues in a person's life can easily be dismissed in the presence of such intractable healthcare difficulties as Fred's alcoholism and homelessness. In the current environment of tight allocation of funds to health and welfare services, people like Fred are often the first to be "defined out of service" on the grounds of non-compliance, the likelihood of poor outcomes or difficulties with personal engagement. Fred may not be able to or want to stop drinking but he was able to achieve much improved safety and an improved quality of life with the carefully mindful support from his new, privately funded, case manager.

At the time of writing this chapter, Fred was in a more comfortable, stable and safe living situation where he could consider and perhaps better manage his drinking problem. The ongoing support of his case manager was important for this improvement. It is not unusual for homeless people or people in residential care to have significant personal funds which are not used. Indeed concern may often only arise when an individual's funds are decreasing rather than when they are increasing or being maintained. Such is the emphasis on wealth creation and management in our society that we have people living in poverty on the streets who actually have substantial estates, managed by conscientious public officers but no case manager to assist them achieve a better life with their funds in practical ways. Financial management of vulnerable people may not generally be considered to be part of healthcare but as can be seen in Fred's narrative, it can influence the accessing of that healthcare.

CONCLUSION

The tensions around the concepts of care and control within health practice relationships discussed in this chapter support the need for human rights discourse as well as highlighting a need for "on the ground" discussions among healthcare practitioners and carers. Careful reflection on difficulties (both actual and potential) inherent in ongoing health practice relationships can enable practitioners and carers to optimally manage and feel comfortable with the difficult processes within such relationships. Feeling uncomfortable about tensions regarding care and control within relationships is not a good reason for staying silent or inactive. Rather, it can provide a warning flag for practitioners to promote careful and ongoing consideration and positive caring action to safeguard the best interests of patients and clients. We have to notice, to listen and then act; individually and together.

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23. HEALTHCARE RELATIONSHIPS

Stories from a Family Member and a Health Professional

This chapter describes some of my experiences with professionals who provided healthcare to members of my family who had cancer. Some of these healthcare relationships were longer term, some short-term and some fleeting. Each had a different impact. From my perspective, the most beneficial healthcare relationships were those in which the healthcare professionals behaved with respect and dignity towards my sister, father and mother, and provided them with high-quality individualised care. They showed that they considered me a valued "support" person and provided information that enabled me to optimise the support and care I needed to give to my relatives.

SETTING THE SCENE

My younger sister Helen, my father Alec and my mother Judith each had cancer and received treatment from multiple healthcare professionals as a result of their cancer diagnoses. My relationships with some of their healthcare providers developed primarily through attending appointments and visiting during hospitalisations. In this chapter I explore these relationships in separate narratives for Helen, Alec and Judith. The order of these narratives is for personal reasons. I wish to acknowledge the many other family and friends who provided support and care to Helen, Alec and Judith during their illnesses and to clarify that this chapter contains my experiences and viewpoints only.

HELEN

Helen was diagnosed with breast cancer in 2005. At the completion of her initial treatment and following multiple tests, she was considered "cancer free" for almost four years. Between 2010 and 2012 Helen had a number of recurrences of her cancer, with periods of being "cancer free". Sadly, in August, 2012, Helen died at 52 years of age. She was a courageous, resilient woman, mother, wife, friend, colleague and sister. Helen and I were sisters and close friends all her life.

During her illness I accompanied Helen to many of her appointments with healthcare professionals and developed different relationships with each of them. Regardless of my relationship with the individual health professional and the frequency of my interactions with them, I always observed Helen's relationship with them and its impact on her mood. Following Helen's diagnosis with brain

J. Higgs et al. (Eds.), Health Practice Relationships, 195–202.

tumours in late 2011, she requested that I attend all doctor's appointments with her and her husband.

Seeking a Second Oncologist's Opinion

In May 2012, Helen was diagnosed with a lung tumour. Her oncologist recommended that Helen obtain a second opinion. Helen, her husband and I attended two appointments with the second oncologist, who was polite, calm, provided us with clear information about the lung tumour, explained test results, potential treatment options and outcomes and placed all this information in the context of Helen's broader diagnosis of metastatic breast cancer and her prognosis. Although the oncologist's interactions clearly focused on Helen as her client, she included Helen's husband and me in the conversations and invited Helen and then us to ask questions.

At this time, part of my role when attending appointments with Helen was to prompt her to provide key information to the doctors and other health professionals, including the physical and cognitive impacts of her cancers and their treatments. Helen and I had discussed this prior to my involvement in this way. As a health professional, I was aware of some of the types of information that another health professional might wish to know, that could impact on treatments but which Helen did not always readily provide. As I learned, Helen was understandably primarily focused on her symptoms on the day of the appointment or the previous few days and not always further back. She was also understandably anxious about these appointments and the potential outcomes of test results. At all appointments, I also assisted with documenting and consequently later recalling the information provided by health professionals.

Helen's Gentle Palliative Care Doctor

In 2011, Helen decided to attend regular appointments with a palliative care doctor. She made this choice primarily for reasons of pain management and to become known to the palliative care service before the traditional notion of palliative care at "end of life" was required. I attended each of these appointments with Helen and her husband.

The palliative care doctor was calm, empathic, professional, a skilled communicator and highly knowledgeable about pain management and cancers including their physical and psychosocial impacts, treatments and their side effects. She included Helen, Helen's husband and me in all conversations. Her manner and interactions indicated that Helen was her primary client but that Helen's husband and I were her clients too. She clearly indicated the importance of Helen's husband's and my involvement in Helen's treatment and care and the importance of us having adequate knowledge. The palliative care doctor further made it clear that the information the three of us provided was valuable in enabling her to provide optimal treatment for Helen. She kept a focus on Helen's quality of life. The second pain medication the palliative care doctor trialled was highly successful and this option enabled Helen to remain pain-free for the remainder of her life. This had a wonderfully positive impact on Helen's quality of life.

Helen's Wonderful Oncologist

From May, 2012, I attended all appointments with Helen's oncologist, with Helen and her husband. Helen had enormous respect for, and a good relationship with her oncologist. The oncologist explained information clearly and listened and responded to Helen's questions and those of her husband. While appropriately indicating that Helen was her client and the most important person in the interactions, she welcomed my inclusion in Helen's appointments and included me in the provision of information and in her invitations to ask questions.

When Helen was first diagnosed with cancer she was not happy with the oncologist she was referred to while in hospital. She did not perceive that they had developed a relationship that would optimise her recovery from the cancer. At that time, I sought the advice of a colleague about the best oncologist for Helen and was given the name of the woman Helen later chose to see. Helen was always pleased with this decision.

I was highly impressed with this oncologist's respectful, empathic manner with Helen and with her expertise. Her interactions and treatments were highly individualised for Helen. Although she had to give Helen devastating news on five occasions when Helen had recurrences and required more aggressive treatments, she did so with empathy, grace and compassion. She explained Helen's prognosis with clear information and without giving expectations of hope or false hope. I held Helen's oncologist in the highest esteem.

In mid-2012 Helen's health deteriorated and she was hospitalised for an operation. Unfortunately this was not successful and Helen's health deteriorated further. As soon as the oncologist was informed of Helen's deterioration, she and two other doctors visited Helen in her hospital room. All three doctors, Helen's oncologist, surgeon and the intensive care specialist, behaved with empathy and respect towards Helen. Helen was pleased and relieved that her oncologist was present. At that time, Helen was having difficulty breathing and requested that I speak on her behalf. All doctors respected and accepted her decision and my involvement. After Helen's husband arrived, Helen was moved to the intensive care unit (ICU). The oncologist provided Helen's husband and me with information about Helen's condition and prognosis with compassion, empathy and respect. Helen's oncologist had to tell us that Helen probably only had very limited time to live and let Helen's husband know that it was important to ask Helen's children to come to the hospital. Helen's husband and I truly appreciated that Helen's oncologist had provided this information to us herself.

Three days later Helen died. Her oncologist had visited her in ICU each day. Helen greatly appreciated these visits, which assisted to keep her relatively calm in stressful times. Although I only saw Helen's oncologist once after Helen was transferred to ICU, knowing that Helen was calmed by her oncologist's visits helped me to manage this difficult time. Helen's oncologist visited Helen, Helen's husband, her children and me just before Helen died. We felt very supported and comforted by her presence. Helen's oncologist cared for her as a client and person and provided her with the best possible individualised healthcare for 7.5 years. This helped her to have quality in her life and at the end of her life and also helped me to cope with Helen's illness, her death and the grief associated with her death. It continues to assist me now.

Helen's husband, her daughter and I visited Helen's oncologist about a month after her death to thank her. She was appreciative of our visit and again expressed her sorrow at Helen's death. She asked about us and about Helen's son. We feel fortunate that Helen's oncologist was a professional, empathic, knowledgeable, skilled and compassionate person. Helen had a strong trusting relationship with her oncologist which helped to sustain her through some extremely difficult times in her life. I highly valued the relationship I had with Helen's oncologist.

Attending Appointments for Tests

I often accompanied Helen when she attended appointments for tests. I did not form relationships with any of these staff members. In this fleeting contact, however, I became clearly aware of the importance of advocating for Helen at times. On one occasion, Helen was particularly anxious about the tests she was required to undertake. Although I was unable to enter the room in which the tests occurred, Helen wished me to sit outside the room. Initially the staff member was reluctant to agree to this request, but when I firmly explained that Helen was anxious about the tests and wished me to sit outside, she found a place for me to sit. The staff member was clearly not happy with the situation, I expect because it was outside normal hospital protocol, but Helen and I appreciated this gesture.

JUDITH

My mother, Judith, was diagnosed with cancer in 2012 and died approximately six months later in October. Mother died three months after Helen's death.

Mother's Oncologist

After my mother's diagnosis with cancer, when she was an inpatient in an acute hospital, mother requested a meeting between her oncologist and me. This followed a conversation she and I had in which she asked if I would talk with her oncologist. I then explained that family meetings were common in the healthcare organisation in which I worked and could consequently be organised in her hospital if she wished to request one. A meeting was subsequently organised but my mother confused the time of the meeting, resulting in several phone calls between the oncologist and me out of normal work hours. He was accepting of this confusion and my multiple phone calls. As a result, the "family meeting" did not occur and the oncologist explained my mother's diagnosis, treatment and prognosis to me by phone, with my mother's permission. The oncologist readily answered my questions and concerns. I explained to him my mother's decision to only inform her children of her diagnosis with cancer and her decision to be minimally informed about her disease and her prognosis. I informed him of my mother's stated decision to essentially ignore her cancer diagnosis at that time. My impression was that although he viewed this as unusual, he accepted it and continued to provide my mother with high-quality medical care.

During outpatient appointments, my mother's oncologist ensured that his interactions were focused on my mother as his client. This was entirely appropriate. He also included me in these conversations, which was essential as I needed to provide the critical information that my mother was unable to articulate as she was largely in denial about having cancer for most of the final 6 months of her life. I also needed to hear his advice as my mother was unable to attend to this information during the appointments or to recall it subsequently. Mother's oncologist also adapted his explanations of her disease, treatment and prognosis to include both my mother and me, and in a manner respectful of my mother and her choice to largely ignore information about her disease. He accepted and appeared to value my involvement in my mother's healthcare.

Following her diagnosis of cancer, each time my mother had a significant health problem, I phoned the oncologist to obtain his advice on the relevance of this health problem to her cancer and consequently her treatment. These phone calls were short, focused, infrequent and he readily provided his opinion. I strongly appreciated the oncologist's willingness to provide information even though each time I needed to phone him, his opinion was that my mother's symptoms were suggestive of a further deterioration in her condition and a probable consequent reduction in her life span. At this time, I was also in close contact with my mother's GP and updated each doctor on the other's advice to me. My mother's oncologist and GP respected each other and were in contact as needed. The GP was managing my mother's illnesses on a day-to-day basis. She saw him frequently.

Mother's General Practitioner

Mother's GP had known her for many years prior to her diagnosis of cancer. In my opinion, he managed her health, illnesses and personality exceptionally well. After my mother's discharge from hospital following her cancer diagnosis, she requested that her GP contact me by phone. From that time, I had regular contact with him, either when I attended appointments with my mother or by phone. In the last month of her life, I phoned the GP approximately weekly. He was always readily available to talk with me by phone and to honestly discuss my mother's condition and treatment. Towards the end of her life, the GP and I discussed palliative care options. As with the oncologist, I strongly appreciated the ability to discuss my mother's health issues and quality of life with her GP. The healthcare relationships I developed with mother's GP and oncologist were essential to the provision of optimal healthcare to my mother through the open and honest sharing of information about my mother's condition, particularly as she was not a good reporter of her own health and largely chose to ignore her cancer diagnosis. After my mother’s death, both the GP and oncologist contacted me to offer their sympathies to me and the other members of my mother’s family.

Mother’s Palliative Care Hospital

In the final 2 weeks of her life my mother was in a palliative care hospital. This was of marked benefit to my mother and her family. The staff were understanding and caring, and treatment focused on quality end of life care. In the last few hours of my mother’s life I left her room, distressed and feeling that I could no longer stay with her until she died. One of the nurses observed my distress and spoke calmly and kindly with me in a quiet area away from other people. She explained that if I wished to leave, my mother would be well cared for by staff members. She told me that staff did not judge people on whether or not they were present when their family member died and that whether to remain or leave was my choice. This conversation gave me the strength to return to my mother’s room, turn up the music on my iPod and to stay with my mother until she died. This was my choice. I do not believe that it is essential for others to be with a loved one when they die. This may not occur for many reasons, and people should not feel guilty when circumstances or choices do not enable them to be present at someone’s death.

ALEC

My father had prostate cancer, which was well controlled for a number of years with medication. In November, 2009, tests indicated that the cancer had spread. Well informed by his oncologist about the evidence relevant to different forms of treatment for his disease, he decided to undertake chemotherapy and radiotherapy.

Father’s Radiologist

I attended a number of radiotherapy appointments with my father. The doctor directed all conversations to my father although he accepted my presence at these appointments. My father often asked the doctor to explain aspects of his treatment to me. The doctor provided these explanations. I do not consider that I developed a relationship with this doctor although my father was confident with him and liked him. My father, however, greatly appreciated my attendance and support at these appointments.

Father’s Supportive Oncology Registrar

In April, 2010, my father was admitted to hospital due to breathing difficulties as a consequence of the spread of the cancer to his lungs. He died 2 weeks later, with Helen and me by his side. Two days after my father was admitted to the palliative care unit his oncology registrar rang me, at my father’s request, to inform me that my father had advanced cancer and very limited time to live, although she did not believe that it was yet time to call in all the family to the hospital. In the final 2 weeks of my father's life I had regular face-to-face discussions with the oncology registrar. My father had enormous respect for her and was not fearful of dying. The oncology registrar kept my father and me well informed about his condition and my father requested that I inform my mother and the rest of the family.

Father's Respectful Cardiology Ward Team

Although he was admitted to the palliative care unit initially, my father's underlying heart problems and breathing difficulties resulted in his admission to the cardiology ward approximately 4 days after admission to hospital. My father's last week of life was spent in the "lower level" intensive care section of the cardiology ward, wearing an oxygen mask. Around this time, following consultation with the oncology registrar, my father made an informed decision to have medication for his pain but no further medical interventions. My father died on this ward in a single room there he was moved on the final day of his life. During this short but highly intense and stressful time, I had regular contact with the nursing staff and the oncology registrar, all of whom provided the best possible care for my father. The cardiology ward staff were more used to saving people following heart attacks than providing healthcare to a lovely old man dying of cancer. They were exceptionally kind to, and understanding of my father and me and certainly made this time of our lives significantly calmer and more valuable than it otherwise would have been. They treated my father with great respect and dignity. This was important to me. They answered our questions and supported our decisions. They made my father as comfortable as possible. The relationships I formed with particularly four of the staff were instrumental in my coping with this very stressful time in my life, in calmly providing care to my father and in knowing that he was being given the best possible care at this stage of his life. They provided information in a respectful manner, repeated information when we were unable to attend to or retain it, and related to us as individuals providing support and empathy. My relationship with these healthcare professionals and knowledge that my father had optimal healthcare in his last stage of life and a "good death" also helped me to grieve for him in a healthy manner.

REFLECTIONS

The affirmative relationships I formed with key healthcare professionals providing treatment for Helen, Alec and Judith following their diagnoses with cancer were important for me as well as for them. The healthcare relationships in which Helen, Alec and Judith were treated with respect and dignity and in which I was considered a valued support person and integral member of the broader team were the most beneficial. They enabled me to provide essential care and support to each family member with adequate knowledge of the disease process and treatments. I felt that Helen, Alec and Judith each received optimal individualised healthcare. Such positive healthcare relationships helped me to manage the shattering experience of having family members diagnosed with cancer, undergoing cancer treatments with all their side effects, experiencing the cancer's progression and ultimately dying of those cancers. I believe that these positive relationships with healthcare professionals also indirectly assisted me to manage the grief associated with each of Helen's, Alec's and Judith's deaths.

My relationships with these health professionals were effective for a number of reasons. Each professional was highly skilled, an effective communicator, empathic and understanding with Helen, Alec or Judith, and indicated that they valued my involvement. My involvement in conversations with them was mostly short and focused and at the invitation of Helen, Alec or Judith or with their agreement.

A further contributor to these relationships was my fortunate position as a healthcare professional with knowledge of NSW healthcare systems. This made me feel confident in negotiating relationships with some of the healthcare providers for Helen, Alec and Judith and assisted *their* confidence in negotiating healthcare relationships themselves. Helen, Alec and Judith perceived that I could provide them with information that would assist them with their illnesses when they wished this assistance. I could support them with their decision making about their illnesses and in their relationships with their key healthcare professionals, as they wished.

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EDWARD G. STEWART-WYNNE AND FIONA MACDONALD

24. INTERPROFESSIONAL TRAINING WARDS

This chapter describes the process and outcomes of bringing a number of people together to establish an interprofessional training ward. Interprofessional training wards provide real-world practical experience for students and staff (of both the hospital and universities involved). The interprofessional student training ward described in this chapter is located at the Royal Perth Hospital (RPH). This training ward began in September 2010 as a pilot project, in partnership with Curtin University's Interprofessional Practice Directorate and the University of Western Australia's School of Medicine and Pharmacology. Final year students from six professions are involved in the care of acute medical patients, under the supervision of a full-time nurse facilitator and part-time facilitators from the other professions. The training takes place in a six-bed medical ward room. The focus is for the students to learn with and about each other while providing patient-centred care. A patient advocate from the Health Consumers' Council talks with the patients each week and provides feedback to the students.

SETTING THE SCENE

The first interprofessional student training ward in the world was developed at the University Hospital, Faculty of Health and Sciences, Linköping (Wahlström & Sandén, 1998). This was followed by similar interprofessional training wards in three of the Karolinska Institute's Teaching Hospitals, Stockholm (Ponzer et al., 2004). Other interprofessional wards were introduced elsewhere in Sweden, Denmark and the United Kingdom. Most were located in orthopaedic wards. Nomenclature has varied from training ward, multiprofessional training ward, clinical education ward, interprofessional training unit to *student training ward* [STW], which is the term used in this narrative.

The RPH STW is a six-bed room on a 26-bed general medical ward, which operates Monday to Friday from 7:00am to 3:30pm. It was established in 2010 and is the first interprofessional STW in Australia. For a detailed review of how this ward was established readers are referred to Brewer and Stewart-Wynne (2013).

Planning took place over 10 months, with several meetings and a site visit to the forerunners of interprofessional training wards in Sweden. Selecting the appropriate ward required identifying a champion whose focus was on interprofessional education and collaboration, as well as a suitable environment in which to locate the students and patients. The ward chosen was a general medical ward. A number of stakeholders were involved in the establishment of the STW within this general medical ward: the physician whose patients would be cared for, the senior nurse in charge of the ward, the heads of department of the allied health professions involved, the head of school of medicine at RPH, the director of interprofessional practice at Curtin University and the

J. Higgs et al. (Eds.), Health Practice Relationships, 203–210.

heads of the relevant schools within the Health Sciences faculty, the Hospital's executive committee, and a representative from the Health Consumers' Council.

In the STW, a maximum of eight final year students from nursing, physiotherapy, occupational therapy, social work, medical imaging and medicine, with pharmacy interns, undertake all ward duties as an interprofessional team, providing patient-centred care to six patients. The students have a full-time nurse facilitator with them for the shift and access to part-time facilitators from the other professions, whom they meet on a daily basis. The usual ward routine includes handover from nursing night staff, introductions to patients, checking of charts, recording of observations, administration of medication, assisting where necessary with breakfast, preparation for any tests or investigations, assistance with personal hygiene and preparation for consultant rounds. Preparation for ward rounds requires students to have all assessment results ready to discuss with the consultant and team. The students also provide a formal handover to the afternoon nursing staff shift, using the iSoBAR checklist (Porteous, Stewart-Wynne, Connolly, & Crommelin, 2009). As an example of discipline roles, the medical students write up medication charts and requests for investigations and consultations – these are all checked and countersigned by the ward's medical staff. The students' words describe a clinical placement in a STW:

> [Nursing student] There were students from different disciplines … we worked with a pharmacy, physio, social work, radiology and two medical students, and we all kind of worked together in this one room. We had a six-patient load, to see how each one of us worked. We got to teach each other about what we did and our roles.
>
> [Pharmacy student] There's seven of you, and you're looking after six patients, so there's a lot more staff than you would normally have, but it gives you a chance to go around with each of the other students and see [what other professions do].

PRESENTING THE NARRATIVE

Orienting Students to the STW

The 2-week placement commences with an orientation day. As well as being provided with information about the philosophy behind and expectations for the STW, students participate in a team-building exercise. The rationale behind this exercise is to highlight skills required to work as a team, such as communication, organisation, and prioritisation of tasks and leadership. After dividing into two groups students are given 3 minutes to present their interpretations of the "fight and flight" responses: tremor, tachycardia, pilo-erection and sphincter tightening, all in mime! Some groups have been highly original in their presentations. Asking students to mime the exercise explores the importance of nonverbal communication such as posture, facial expressions and hand gestures. In recognition of their acknowledged self-consciousness about presenting in front of each other, students are always applauded and thanked for their efforts.

Once on the ward, the students are encouraged to work together in pairs so that they can learn from each other as they perform their profession-specific assessments. They are asked to organise their workload among themselves, with very little input from the nursing facilitator. After an initial period of indecisiveness, teamwork can build quickly and students can feel more confident in themselves and their abilities. The following is a student's comment about the first day:

> [Pharmacy intern] [The] first day [was] crazy, we didn't know each other or what we were doing, [we were] disorganised, but got a flow from then on. It's not just pharmacy now, I help where I can, am aware of what everyone else is doing, appreciate each other's role, makes it level, that we're all important, have more respect for everyone now, knowing what everyone does. Become friends as well as colleagues. I feel more confident in my own role now, feel ready for next year.

Communicating and Working Together on the Ward

Communication in a fast-paced ward can be challenging but it is an essential skill to ensure good teamwork. The iSoBAR tool ensures that pertinent aspects of a patient's condition are highlighted, handed over and acted upon [i = identify, S = Situation, o = observations, B = Background, A = Agree to a Plan, R = Readback]. As well as using iSoBAR, students are encouraged to find the best way for the team to communicate effectively with patients, with each other and with the interprofessional team. From the students' points of view, communication, learning about other professions and working together tend to be intertwined.

> [Medical student] Communication – all working together has a really good outcome for the patient, I have a greater understanding of pharmacy role, not just a purple pen! Taking on responsibility, working well with the team. Nurses are good with lots of tricks up their sleeve. I like to ask them, which I don't usually do.

The inclusive nature of the consultant ward rounds has been an important element of students learning about each other's roles and feeling valued for their own roles. During the ward round, all students must be present and share information gained from their assessments:

> [Occupational therapy (OT) student] I enjoyed the ward rounds and feel valued as part of the team – sometimes feel that allied health gets pushed to the side a little bit. All students in allied health should have a go at this. I have definitely understood everyone else's profession and such an amazing opportunity to follow the med students around. I have worked with physios before but [I was] able to actually see what they do and understand the assessments that are done. … [It is] a really important thing to see how the OT role fits in with the other health professionals.

> [Physiotherapy student] [During the ward rounds] I got knowledge from other students, felt valued when asked my opinion and we all picked up on different things beneficial to patient care.

> [Nursing student] Everyone has been willing to teach [on the ward round] but the biggest thing is to be willing to learn. Questions asked have been taken on board and the best thing is that we value each other's opinion, nurture everyone in a holistic way so patients are getting the best care. This prac has been more empowering compared to others … able to take more ownership. [It] forces you to take a step forward, growing in confidence.

In the opinion of the authors, the feeling of being valued and having one's opinion listened to can be largely attributed to the consultant's style of ward round. Particularly notable was the way in which he involved everyone in patient care, especially the patient. One nursing facilitator explained this as follows:

> It works beautifully. Why? Because of the personalities of the role models, particularly the physician – courteous, inclusive, empowering, polite, engaging and highly respected. When a consultant with these personal attributes appears on the ward with expectations of the student team, the norm is to try hard to match the set standard and to meet or exceed his expectations, because he is a decent, courteous human being who treats people in a fine and dignified way regardless of their profession and regardless of their seniority. The quality of communication that transpired daily in this context exceeded the performance of most "qualified" teams.

Valuing Patients' Insights and Feedback

The role of the patient advocate in the STW is extremely important is unique to RPH. The position was sourced through the local Health Consumers' Council and its aim is to build mutual effective working relationships between healthcare professionals and patients/consumers before the student enters the workforce. The patient advocate explained her role and impression as follows:

> As the patient advocate on the STW I visit each patient twice during the students' 2-week prac. I ask the patients for feedback that I can pass on to the students. Most patients are surprised at being asked about their experience of being on the ward, and some patients are delighted that they are able to be co-educators to the students. If a patient can't think of anything to say I ask them whether they are getting all the information they'd like regarding their condition and whether they feel the students are working together/as a team to care for the patient. From what I have been told by both groups, being on the STW is a positive experience for patients and students alike.

Patients' feedback, as shown below, highlights the value of the STW for patient care and student learning. Some patients asked to return to the STW if re-admitted!

> The student nurses did their utmost to insure we patients received the best care – they listened and responded quickly and pleasantly, as you would hope. The student doctors answered my questions concerning my heart complaint and relayed the consultant's information with care and consideration. [Female aged 71]

> [Name] had a wonderful team looking after him. The love and care was excellent. Thanks a lot. [Spouse of male aged 81]
>
> All students should go through the same training. [Female aged 80]

Debriefing and Making Sense of Their Involvement

Opportunities for regular debriefings are an important aspect of the STW. Students and the profession-specific facilitators have the opportunity to debrief with each other at the end of each day. In this way, issues arising during the day can be discussed in a safe environment. Facilitators aspire for students to carry the feeling of openness of communication and collaboration between professions into the future, as one facilitator shared:

> Feel confident to talk to each other, try to keep this [confidence] when you go to work. Be confident in your area, you are the professional in your area. Don't be too shy to say "this is what I think" – carry it on! (Pharmacy facilitator)

A final debriefing at the end of the second week allows the team to come to an end, celebrate achievements and reflect on time on the ward. At this debriefing, students are encouraged to compare their initial aspirations with their actual experiences. The quotes below provide examples of particular students' Day 1 goals and comments (in italics), followed (in normal type) by the same student's comments on Day 10.

Medical student: *Communication, my role, time and task management*

> [It was] good getting to know the team on a first-name basis [and] learn what each role is and how they fit in to the hospital. [I had] a lot more independence, more logistics, more jobs to do. This was at the expense of medical learning which was interesting as a change and only a short period of time.

Nursing student*: I want to understand how we work as a team and how we need to communicate as a team regarding the patient. I want more confidence to initiate care, make clinical decisions*.

> I got a chance to initiate my care, tried to be more organised, got to know the role of the pharmacist and OT and we are helping each other, enjoyed the ward rounds, feel more confident in talking to senior consultant. Yesterday, I didn't want to talk but today I really wanted to jump in front and say everything about my patient. It has been excellent, built up my confidence, how to act more professionally.

Occupational therapy student: *I'd like to be more independent*

> Not having your supervisor there all the time [was] very beneficial. [I] knew the role but to learn and carry it out was a great way to cap the year off. I have been in interprofessional teams before. The main thing with the STW [is that] all

> students, all level playing field, no question is too silly, willing to communicate, take time to validate each other's role, bring own expertise to [the] team and an opportunity to educate others.

The reflections of facilitators also provide insights into their experiences on the STW. As described below, providing such guidance and support can be both exhausting and rewarding.

> [Nurse facilitator] At the end of the very first 2-weeks rotation I was exhausted. I had never realised just how much hard work is involved in keeping my hands behind my back and my mouth closed.

> [Nurse facilitator] When offered the opportunity to provide [nursing] facilitator cover… I jumped at the chance. I have worked in some form of education for half of my 34 years in nursing – what was there to learn? It should be a breeze! My experiences were both joyous and frustrating – it was way more challenging than I expected. Here the goal is to stand back and bite your tongue to allow the team to find its own identity – its own strengths. In this environment the team has to dig deep and discover the ability to provide a collegiate support and development function for itself through the active management of real clinical management in a busy ward. The hands behind the back approach was tough to adapt to and forced me to learn a whole new approach to teaching. Amazing! Old dogs – new tricks! If offered the opportunity to facilitate in an interprofessional training context. What's my advice? You should jump at the chance for this unique professional development opportunity. You will learn much about interprofessional learning but you will learn much more about yourself as an educator. It will be everything you expected and more, but it will never be easy!

> [Nurse facilitator] From the facilitator's perspective, I have thoroughly enjoyed being involved in the STW experience. I hope the STW becomes a sustainable program as I see it being very beneficial to students in preparing them for the "real world".

Although not a mandatory requirement, forms are available to students to use if they wish to give feedback about the facilitators. Feedback tends to be positive and often expresses appreciation of facilitators' guidance, support, trust and respect.

> [Social work student] Supervisors were very supportive of me while on the STW. I felt that they really trusted me and while I always felt guided and supported, they did not take over which gave me a real chance to experience being a professional, independent social worker, which I really enjoyed.

The clinical nurse specialist (a very experienced and highly respected ward leader) offered her perspective of the STW:

> The STW is an ideal model in fostering a collaborative approach to the patients' journey from the whole team. Ward 5E has embraced the STW, interacting with the students daily, providing additional support and

> promoting an interprofessional team approach to patient care. I have been able to see an increased interprofessional approach in the rest of the ward area, as a direct result of having the training ward on ward 5E.

The medical registrar of the consultant's medical team commented as follows:

> I found the STW an enlightening and rewarding experience, not only for the students involved but for myself. I feel its major benefit lies in the experience the students gain from working as part of a team, focusing on the same goal, i.e. the best outcome for our patients. During the process of achieving this the students were required to undertake tasks which were outside their own professions usual responsibilities, giving them an insight into the role and value of other healthcare professions which they would otherwise not gain. Inevitably this resulted, in my experience, in the development of a mutual respect and acknowledgement that within our system we cannot work independently of each other if we aim to do the best by our patients. I hope the students carry this through their professional careers.

A final insight for this narrative chapter is from the physician whose patients were cared for on the STW, who commented on the need for a visionary approach and the resulting success:

> The idea was counterintuitive and challenging. Students from the clinical professions of medicine, nursing, physiotherapy, occupational therapy, pharmacy and social work would assume the clinical care of a room of six patients in a general medical ward. Other clinical departments had been approached but dismissed the concept out of -hand. Too difficult, care would be compromised, even dangerous. But it went ahead. Supervisors were approached and appointed, universities came to the party, somewhat reluctantly in some cases, and a trial STW was up and running.
>
> We shouldn't have worried. The initial cadre of students (two medical, two nurses, one each from the other professions above) duly arrived, and set about showing all of us just how well they could look after patients ranging from 20-year-olds with pyelonephritis to 80 year olds, bedbound and confused. There was plenty of supervision, and regular meetings with individual supervisors. Research into hand-over techniques, and subsequently ward rounds, was embraced.
>
> Two years on we can say that the STW has served its purpose well. The students see it as the most helpful of their clinical attachments, the patients enjoy the familiarity of dealing with them daily, and the senior staff have seen no compromises in patient care. The students have commented on the pivotal importance of nursing in the hospital setting, and the knowledge gained by simply discussing the various specialty interventions with their interprofessional colleagues and, now, friends. The STW is here to stay!

REFLECTIONS

From the foregoing it is apparent that patients, students and members of staff all shared the view that the concept of the STW and their involvement in it provided valid and valuable experiences for all. The recognition that patients (and their family and carers) are central to and equal partners in the process is fundamental to this success. Collaborative practice allows professionals to better understand each other's roles and to recognise that it is a complementary rather than a competitive way to practice. Moreover, all concerned not only learned with, from and about each other but learned more about themselves, too! Themes that have emerged from this narrative include the importance of communication, the self-confidence that develops during the placement, and having mutual respect for all.

In STW the opportunity arises to undertake research in various aspects of the healthcare process: students' valuing interprofessional education (IPE); evaluating the iSoBAR hand-over checklist; assessing the IPE ward round process; assessing patients' and carers' involvement in their management, to name but a few.

Several challenges become apparent: the need to expand the process to allow all health science students the opportunity for similar IPE placements; the need for the various schools within the Faculties of Health Sciences to practise as well as teach the principles of IPE and interprofessional practice, and finally the need for healthcare workers to embrace these principles in their day-to-day work.

> By three methods we learn wisdom:
> First by reflection, which is noblest;
> Second by imitation, which is easiest; and
> Third by experience, which is bitterest.
>
> Confucius

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25. THE BENEFITS OF LONGITUDINAL RELATIONSHIPS WITH PATIENTS FOR DEVELOPING HEALTH PROFESSIONALS

The Longitudinal Student-Patient Relationship

Clinical placements are widely acknowledged as essential to the holistic development of health professionals, with the ability to engage in professional practise in patient-centred healthcare models providing one example of this holistic development. These placement experiences have historically involved a series of short-term rotations between hospital-based disciplines, continuous with or interspersed between short blocks of theoretical learning. While the student-clinician (preceptor) relationship is central to student learning outcomes, these short-term placements often offer students little opportunity for developing relationships with patients, or for continuity of care experiences. Investigation of an alternative clinical education model for medical students, the longitudinal integrated community-based clerkship, has revealed that patients are important participants in the patient-student-preceptor triad that develops. In this chapter we present patient, student and preceptor narratives to illustrate how longitudinal relationships between students and patients can play a significant role in the student journey to "becoming" a patient-centred health professional.

SETTING THE SCENE

A newly established graduate-entry medical school in New South Wales (NSW), Australia, with a mission to develop medical workforce for regional, rural and remote Australia, directly addressed its challenging objective through provision of quality long-term clinical experience in these settings and affirmative action in admission of students of rural origin. The former included a year-long placement mid-way through year 3 (phase 3) in the 4-year Bachelor of Medicine, Bachelor of Surgery (BMBS) course. All students are allocated to a general practice in a regional, rural or remote community for one integrated (community and hospital care) academic year (Hudson, Weston, & Farmer, 2011). In this model of a longitudinal integrated clerkship (LIC), the student takes part in acute and chronic patient care in general practice, community settings, hospital wards, surgical theatres, delivery suites and emergency departments. In the 2 days per week in the general practice, students can accrue a panel of patients who consult them throughout the year under preceptor supervision.

J. Higgs et al. (Eds.), Health Practice Relationships, 211–218.

In this longitudinal model, ten regional (non-capital city urban centre), rural and remote teaching and learning hubs were established to host and provide all students with a LIC experience in a community in NSW. Academic and general staff were recruited in each site to support students and other members of the teaching and learning community. Considerable time was invested in building the relationships between the university and each community to establish the human and infrastructure resources required for this whole-cohort LIC initiative. The student-patient relationships that developed in each community as a result of this longitudinal placement experience are the focus of this chapter.

In medical education, *clerkship* describes the practice of medicine by medical students in the final and/or penultimate year of undergraduate training. Traditionally, this has comprised a series of hospital-based speciality rotations, ranging from 2 to 12 weeks under the supervision of a clinician. The latter, a skilled practitioner who supervises the student's practical experience with patients, is referred to as a *preceptor*. In longitudinal integrated community-based clerkships, the main preceptor is the supervising general practitioner. Long-term placement in the general practice provides the environment for the development of a student-patient-preceptor triad with influence on student "belonging" within the healthcare team, and "becoming" a health professional (Hudson, Knight, & Weston, 2012). Patients' trust in their doctor, developed during long-term professional relationships, facilitated acceptance of the student into the established partnership to form a learning triad (Hudson, Knight, & Weston, 2012).

As a general practitioner and academic with life and work experience in rural and remote Australia, Nicky Hudson led the team establishing and researching outcomes related to the LIC initiative. A general practice placement in remote South Australia was a highlight of her undergraduate medical education. In that setting and with the consent of the patients, Nicky was able to take an active role in community and hospital patient care under close supervision of her GP preceptor. Reflection on this experience sparked interest in developing clinical education environments where professional relationships with patients can play an important role in student belonging and becoming a health practitioner, in a community of practice. Kath Weston, a public health practitioner and academic, with experience in building research capacity of primary healthcare practitioners and in qualitative research in medical education, has made a major contribution to sustaining and exploring the impact of the LIC program.

This chapter presents narratives from patients, students and preceptors in the first few years of the program, providing insight into how long-term relationships with patients are influential in student professional identity formation. These narratives have been inspirational for the authors of this chapter in upholding their commitment and belief in the longitudinal integrated community-based clerkship as a model of clinical placement that fosters the development of patient-centred health professionals.

PRESENTING THE NARRATIVE

This section presents narratives and/or quotes from preceptors, students and patients, illustrating how patient consent to an active role for the student in patient care fosters student learning on the journey to *becoming* a health professional. They also demonstrate outcomes for the patient and the richness of the student experience. An opening narrative from one of the preceptors involved in the program illustrates how and why the practices host a long-term student, providing the foundation on which the student-patient relationship grows.

Narrative 1: From the Preceptor's perspective: Student learning and transition during the long-term placement.

> I think the length of the placement is critical. What happens with the students is they go through a series of sort of phases. So they're babies and then they're school kids, and then they're adolescents and towards the end of the year, they're sort of grown-ups. They're much more useful. That transition takes time and I don't think you can achieve that in less than a year's placement.
>
> It's very important for us to not see it as a general practice term but as a longitudinal community-based placement. What they do in this longitudinal placement is they join lots of dots, and it's like a jigsaw puzzle; it's hard to see where you're going when you first start. I think that when you are at the smaller specialist-based things [placements] you tend to learn all about surgical problems, or learn all about common medical problems, and you learn them as sort of big lumps, whereas how they learn it here in phase three, there's just a whole lot of things and a whole lot of things come together and later in the year we find that they're able to actually get much more of a global appreciation of someone with cancer or airways disease or heart disease or diabetes or something. And suddenly you start to join these dots together and see the ramification for it in a range of ways that they wouldn't see at the start of the term.

This preceptor narrative captures the benefit of the LIC for undergraduate medical students. It describes how students develop and build an integrated knowledge of common conditions during the year, but importantly highlights how the knowledge and learning is developed in a patient-centred way. Subsequent narratives from students and patients further illustrate how the relationship between them facilitates holistic patient-centred learning by students.

Narrative 2: From the Student's perspective: "Nicky, I want to tell you about an amazing experience I had in Phase 3".

> I had been seeing this man in the practice over some months for general healthcare under the supervision of my GP preceptor. When this patient came in with a worrying symptom, we sent off some tests and the results came back to reveal the man had cancer. My preceptor asked if I would like to break this "bad news" to the patient as I, unlike my preceptor, had received formal training in "Breaking Bad

> News" in my communication skills training in the medical course. Critically I had developed a good relationship with the patient and my preceptor felt I would handle this challenge well. We discussed how I would do it, and it went as well as could be expected in a difficult situation. My preceptor supported me through the experience, and the debriefing was valuable. I just wanted to tell you about it as I really felt like I was almost a doctor and knew you would like to hear about it.

This is a challenging situation for any medical professional, and particularly for a student close to the end of undergraduate training, as in this case. Clearly the preceptor believed the student would manage the situation and the student felt able to take on the role given her longitudinal relationship with the patient. Their relationship enabled the student to "become" the health practitioner and she felt so empowered by the experience that she wished to share it. It was wonderful to hear from the student as she also realised she was able to provide patient-centred care as an outcome of her long-term placement. She was excited and motivated by this experience.

Narrative 3: From the Student's perspective: "We both benefited from my long-term relationship with the patient".

> The patient was a 45-65 year old male with gastrointestinal upset on a background of chronic alcohol abuse, cirrhosis and chronic pancreatitis. This man had been lost to the system and was on a slippery downward slope. I saw him on a regular basis. On the first consultation he was very reserved and quite defensive when questioned about his alcohol consumption. Over the consultations I developed good rapport and over the course of the year we managed to significantly reduce his alcohol consumption, gain better control of his diabetes and managed to get him to have a colonoscopy, which was a massive task for him.

The continuity of care experience enabled the student to develop a relationship with this man such that over many consultations they worked together on his alcohol consumption, diabetes control and completion of an important procedure. Both student and patient needed time for the relationship and subsequent outcomes to be achieved. The student recognised the collaborative nature of the student-patient partnership that was in operation: "*we* managed to reduce his alcohol consumption" and notably, the patient was able to address the sensitive issue of alcohol consumption as a result of the rapport created. The student perceived this as a significant interaction, recording it in her clinical log, describing a patient-focused approach to care.

Narrative 4: From the Patient's perspective: "The patient can guide a trainee doctor in the way the care is going".

> Yeah, I think it's good having the student doctor, well like you know there's a lot better service here than at the hospital… the practice here is like a mini hospital and I found her quite competent [the student] and it was just good service, like

> having the extra doctor there, yeah, and she was really good … I made an appointment to see her because she was actually one of the first doctors I saw with [husband] when I first was discharged. She'd seen the open wound; she helped dress it … so she has basically been managing me since I first got out of hospital you know, so I had no problems at all, none whatsoever [seeing the student] … she was another doctor but she's been with me through my whole case with my treating GP … and every time he'd come and consult and it saves a lot of time and it's a better quality of service, 'cos I was getting two doctors for the price of one. I mean I can get in and get seen on a regular basis through my treatment with a doctor who's been with me from whoa to go. I don't think any patient can really help train a doctor. They can probably guide them in the way their care is going.

This narrative highlights the benefit of the student in a busy general practice allowing patient access to her doctor whenever needed as he was supervising the student. The student-patient relationship was initiated on first presentation after patient discharge from hospital, with the relationship continuing each time the patient came to the practice. The patient acknowledges the key role of the doctor in training the student, and she suggests that patients play a role in ensuring the direction of the care, presumably meaning focused on the patient.

Narrative 5: From the Patient's perspective: "Developing trust to contribute to the student experience".

> They are polite and they're thinking of the patient … they are thinking of you and make you feel comfortable. The students listened to him [6-year-old grandson] … he was only six but he knew more than me and his mother knew because he'd been around with the doctors and that. He was *telling* them … they were asking him questions … they weren't talking to him like he was way down here and they were way up here. It was helpful for my grandson too.
>
> A lot of the older ones [in the Indigenous community] think that if they see a student, they're getting pushed aside … and I say to them … they've got to learn. How are they going to learn if we're not willing to say "yes, that's fine" – at the same time we're teachers as well.
>
> The patient is always involved. It's not like the doctor takes the student out of the room, the student is there and actually gets involved. I think it's very good because they're learning a lot plus I think too, the patient is learning trust in the coming … some of these students might be here at the surgery later in life.
>
> I'm hoping they keep on coming because I think they're very valuable to the doctors and to us. But they need the interaction I think with the patients … that's very important. Like [partner] said, you can read anything out of a book … totally different. I mean they're getting to see people like [grandchild] that's very serious, people like me … they're interacting with all age groups. I think they need that and I honestly think the trust needs to be built up between all age groups and medical students. As I say to my daughters … they've got to learn … you need to

> be willing to have them there [at the clinic] so they can listen and ask you questions.

Narrative 6: From the Patient's perspective: "The student was growing with me".

> I find medical students are just … they're willing to learn … they're just a lot more aware of the patient I think sometime. I met her [student] at the very beginning of my pregnancy. I went through a few things like I had to have an amniocentesis and it was nice to have her there and you could see she was upset as well so things like that – small things but then you'd come to visit again and she'd be there so it was kind of like she was growing with me, if that makes sense. I found it very positive the whole experience … and also you know you're helping them with their experience as well. It's a great thing, especially long term, you get that rapport. I think they're all part of the same team. She is eventually going to be where the doctor is so it's just basically a line of progression.
>
> We're a country town so we can always do with extra staffing in such medical practices. Hopefully when they do graduate and everything like that … it gets them back into the country.

The student-patient relationship in this narrative was important to the patient as the female student offered empathetic professional support from another young woman in an all-male-doctor community. The continuous relationship was valued as the patient faced some challenges in her pregnancy. The patient's reflection after the student year – *it was like the student was growing with me* – captures the essence of the longitudinal student-patient relationship. The patient also understood her role in contributing to the future of the rural health workforce, in "rural return" of new medical graduates to the patient's community.

REFLECTIONS

The establishment of longitudinal integrated clinical placements for a whole cohort of medical students required considerable work from academic and professional staff, and time commitment to relationship building between the university and a diverse group of health practitioners, managers, local government and community citizens. The student growth in this educational setting, as told by preceptors, students and the patients, is very pleasing and a wonderful reward for this effort. The continued engagement of students in longitudinal clerkships in these settings will be instrumental in delivering holistic, patient-centred care in regional, rural and remote Australia well into the future.

General practice has been identified as an ideal environment for medical education in the 21st century (Thistlethwaite, Kidd, & Hudson, 2007). However as one preceptor explained above, the placement is not merely a general practice term. Rather, it provided a major setting for student access to a large range of undifferentiated patients presenting for care. In the words of another general practitioner preceptor:

> We've got a huge range of medicine that just walks and wheels itself in the door. People talk about cradle to grave but we actually run from before you're born till after you're dead.

From a base in general practice, supervised and mentored by practitioners and other health professionals who have reported great commitment to their patients and community (Hudson, Weston, & Farmer, 2011), students have a long-term opportunity to practise and learn patient-centred care. The LIC educational environment is underpinned by the principle of continuity: continuity of care, continuity of curriculum and continuity of supervision (Hirsh, Ogur, Thibault, & Cox, 2007). The longitudinal experience allows the student to take part in assessing the patient on presentation and to follow the patient journey back to health or on to chronic care. In addition to a core curriculum from the institution, the curriculum is a real-world continuous one as patients "walk through the door". Rather than provide immediate constructive feedback in a "moment of care", as tends to occur in short-term placements, supervisors play more of a role in the formation of professional identity. In the words of one preceptor, it was:

> the opportunity to give a person what amounts to personal mentorship for nearly a year, you have a very close relationship and a real sense of the professional growth in the person. I think it was exhilarating to watch.

Continuity of students' patient-centred beliefs has also been reported from longitudinal placements, whereas it has been reported that students in some traditional hospital-based clinical placements have demonstrated deterioration in their attitude to patients (Kruput, Pelletier, Alexander, Hirsh, & Schwartzstein, 2009). Continuity of commitment to the patient is evident from the student and patient narratives illustrated in this chapter. Patients willingly allow long-term students to play an active role in their care and the narratives reveal how satisfying patient outcomes have been motivating for students.

The introduction of a large-scale innovation such as the LIC model for the whole cohort of students posed many challenges, particularly when it involved change from established practice and occurred in an environment of increasing medical student numbers and class sizes. An early and coherent implementation strategy was required to attract clinical supervisors in this competitive environment and to build the other human and infrastructure resources required for implementation and sustainability. There are various approaches to making change work and we chose a strategy that included the following processes: defining and disseminating the scope, vision and purpose of the innovation; consulting with stakeholders in each locality; ensuring that the initiative became part of the School's core processes and procedures and implemented University policy and procedures. Enabling factors included continued high-level university support; commitment of academic and administrative resources to develop and manage the curriculum; educational technology to facilitate distributed learning; acknowledging and addressing obstacles and concerns posed by those reluctant to change; ongoing articulation of the vision and purpose of the initiative.

During a full academic year in a rural, regional or remote community, students develop relationships with a range of health professionals in the local hospital and all community healthcare settings, as well as with community members. The latter are the patients that first present to the practice, providing the "curriculum" for student learning. But their contribution to student learning is much more than that. Patients have described the LIC learning environment as learner- and patient-centred. The year-long relationships between learners and patients, where the student is learning from and with patients, allow patients to make a significant contribution to the formation of patient-centred clinicians.

CONCLUSION

Healthcare professionals, healthcare managers/funders, clients, carers, professions, and policy makers would do well to listen to the voices and experiences of the students and patients in these narratives. Those voices suggest that longitudinal integrated clerkships provide a learning environment with great potential to develop patient-centred healthcare professionals.

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SECTION 4: IMPLICATIONS FOR PRACTICE, SYSTEMS AND EDUCATION

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26. HEALTH PRACTICE AND RELATIONSHIPS

Health practice is essentially a human experience that is underpinned by relationships. These relationships form particularly between health practitioners and people who seek health services, between health practitioner colleagues, and between health practitioners and organisational managers. This social dimension of health practice is important because it draws attention to the significance of how health practice is experienced (by both health practitioners and individuals seeking health services) and to health outcomes. In recent years, information and communication technologies have expanded considerably and have many and varied influences on health practice and practice relationships. Unfortunately, the technology and organisational facilities that underpin contemporary health practices can have the paradoxical effect of dehumanising what is essentially a very human experience. In this chapter we consider health practice relationships and focus on issues concerned with the privileging of relationships between practitioners and with clients:

- Health contexts, including organisational and professional networks, have a pervasive influence on health practices and practice relationships.
- The existence of policies, research and education that promote client-centred care is not sufficient to ensure that clients are actually at the centre of health practice. Individual practitioners (and teams) need to take this initiative in real practice in order to keep clients at the centre of health practices.
- Promoting positive relationships in health practice requires a mindful balancing of competing needs to care for clients, colleagues and self.
- There is a need for health practice relationship champions who privilege the development of health practitioner relationship capability, to bring about positive and sustainable change in health workplace cultures, healthcare systems and practice traditions.

HEALTH PRACTICE IS SHAPED BY CONTEXT

Healthcare contexts are important because they have a profound and pervasive influence on the shaping and enactment of healthcare practices, including the formation of relationships embedded in these practices. Across numerous chapters of this book, healthcare contexts have been revealed as diverse, complex, dynamic, environmental and relational spaces that powerfully shape health practices. Healthcare relationships have been identified as operating across interconnected networks within healthcare contexts. These networks include organisational

J. Higgs et al. (Eds.), Health Practice Relationships, 221–228.

frameworks (such as health service cultures and expectations), health practice systems (including professional codes of conduct), and individuals within these networks, including healthcare practitioners and people seeking healthcare services. Thinking of such complex systems as networks provides a useful way to develop a deep and rich understanding of health practice contexts.

Throughout this book the pervasive influence of organisational networks on health practice has been revealed in the highly regulated and legislated nature of contemporary healthcare contexts. This degree of regulation is necessary to ensure quality within healthcare systems. As an example of this regulation, health practitioners are required to work within sets of interconnected obligations and expectations, including professional registration requirements, professional association and organisational codes of conduct, and legal requirements. Organisational expectations strongly shape health practitioners' practice and consequently healthcare experiences and outcomes for health service users, and are broadly visible in the organisational culture (e.g. vision and mission statements as well as staff behaviour and attitudes), practice models and articulation of goals and outcomes. The current drive for efficient use of resources and the consequent privileging of accountability may create a tension between organisational expectations and health practitioners' moral or professional responsibility to provide the best treatment for specific individuals in their unique circumstances. Despite this high level of regulation, health practitioners must remain responsive to the uncertainty, diversity and change that are integral to the unique spaces of healthcare practice and the unique people and relationships within them.

Health practice is also carried out by, with and for people who are inextricably embedded in their broader personal and social contexts. Thus people who provide and seek health services comprise a significant aspect of the context that impacts on health practice and practice relationships. This important aspect of context is not always taken into account, however, although it strongly influences expectations and outcomes of health services. Consider, for instance, the level of emotional, behavioural and cognitive functioning of people seeking health services. People needing health services may be in crisis with an unexpected injury. They may also be more in control with a well-understood long-term condition. Some relationships might be short-term and intense during a crisis period, whereas others might develop over many years.

Health professionals themselves also form an integral aspect of healthcare contexts that has a significant influence on the formation of health practice relationships. Practitioners need to constantly assess people's emotional, behavioural and cognitive mobility and adjust their expectations and behaviour accordingly; they may also need to assess their own emotional and relationship competencies and resilience in the provision of healthcare. In the development of health practice relationships, many health practitioners are challenged by the need to "get the balance right" between the need to be professional but also to be human and approachable. They need to be able to balance providing care with the need to preserve their own resilience and emotional health. This balance could well be different for each individual health practitioner, each different situation and each individual health service user.

PRACTICE RELATIONSHIPS ARE ABOUT US

It would be an unusual (or perhaps brave) person to say he or she did not support clients being at the centre of healthcare. Yet, despite the widespread attention in policy, research, and education for client-centredness, many stories arise of clients not being the centre of care. The busyness of staff can affect their care for their patients, as shown in a patient's poignant quote from the research of Mangset, Erling Dahl, Førde, and Brun Wyller (2008, p. 830), exploring elderly stroke patients' satisfaction with rehabilitation:

> I'd say they don't listen to us. Not at all. They shut their ears when they pass by: "I haven't got time now, I've got to do this and now I've got to do that". It's as though they look back on us when they have passed [and say]: "Oh, thank God, she didn't ask me for anything".

Healthcare organisations have laudably tried to raise the profile of client-centredness within policies and systems but words do not always translate into practice. Even when the intention is client-centred collaboration, the complexity of systems and of practitioner teams and networks means that patients may, in effect, be sidelined. Wertheimer et al. (2008) cautioned that staff being collaborative in team meetings did not necessarily mean they were being staff-centred: collaboration often occurred more between professionals than between clients and staff. Even having clients attend meetings did not necessarily ensure client-centredness. According to Abreu, Zhang, Seales, Primeau, and Jones (2002), patients' attendance at interdisciplinary meetings did not necessarily promote client-centredness; patients were minimally engaged and "appeared subservient and disempowered" (p. 700). The complexity of such relationships needs to be highlighted within the context of client-centred healthcare practice.

In the interest of promoting health practice relationships, it seems sensible to apply the concept of a client-centred approach to all the participants within such relationships: clinicians, carers, clients and families (Berwick, 2009). As part of a client-centred approach to healthcare, practitioners should take responsibility for ensuring that they do not engage with clients as objects of care, but rather as a people with agency and with life contexts. Clients at the centre of care also need to realise that their practitioners have many "client-centred" demands that they need to balance at any one time. A multi-support approach is required at all levels of healthcare, from policy makers, managers, team leaders, through to clinicians, clients, and their carers and families.

The concept of placing clients in the foreground would seem to indicate a focus on the individual client being treated, but such a restricted view could preclude the needs and rights of other people, including the healthcare practitioner involved. Beyond a practitioner's relationship with an individual client, are responsibilities to wider groups of clients. Viewing the complexity of health practice in terms of interconnecting webs can serve to highlight the messy, complicated and interconnected nature of human relationships within that context. These client webs refer to an individual practitioner's client base at any particular time, as well as to other practitioners involved directly in the healthcare program in question, and beyond that to other clients and other practitioners.

Many focal points occur within these webs, each with a client at the centre. When viewing the client as central to each of these webs of care it seems an easy matter to put the client first, but doing so without an awareness of the wider context where that client's healthcare takes place can result in some clients being privileged over others. A patient who absorbs the attention of staff may be the one whose advocates (patient, family, carer or staff member) are the most vocal or powerful. A health professional who insists that another staff member responds to "her" client "now" may lead to a situation of "the squeaky wheel gets the oil", leading to the care of other clients being compromised. Groups of clients may be inadvertently privileged over others in particular healthcare strategies. Similarly, if the notion of caring completely overshadows the notion of counting, we run into the issue of how to pay for everyone's healthcare. This highlights the importance of considering "clients" as well as a single "client" at the centre of a single therapeutic relationship.

EMBRACING TENSIONS WITHIN HEALTH PRACTICE RELATIONSHIPS

Typically, our communities have a greater volume of health needs than can be met by available resources. The essential tension created between "caring" and "counting" provides a conundrum for society and the healthcare it aims to give to its citizens. However, although being measured can be seen as de-humanising the essentially human practice of healthcare, it can also be argued that those who are not "counted" can fall "out of the spotlight" and therefore might not be "served" as well as those who have been included in the counting and measuring process. It may well be that we must be measured if we are to have a voice within society as a whole. It is doing that measuring knowingly and mindfully that counts. The essential humanity of relationships needs to be attended to in order to progress the healthcare process for both clients and practitioners, as do the links of these participants with the wider communities of clients and practitioners. This is reflected in the words of Frank (2004, p. 44), who argued for a deeper level of interpersonal interaction in healthcare:

> My ideal clinic is where each participant – medical workers, patients, volunteers, and friends – sees what is happening in all the possible refractions of the mirrors of one another's perceptions. Each is constantly asking: what does this look like to them, from where they are?

It should be acknowledged that all participants in health practice relationships, including clients, practitioners, families and carers, face the difficulty of establishing and maintaining health practice relationships. From the practitioner's point of view, the collective and its need to be measured should not interfere with the "presence" or "mindfulness" needed when that practitioner is with an individual client. To be there, to be present, is all about noticing what is going on with a patient. Practitioners can only be responsive (salient) if they are present (van de Cingel, 2011, p. 678). "The body I experience cannot be reduced to the body someone else measures" (Frank, 2002/1991, p. 12). Measurement cannot capture the nature and essence of human experience and the meaning that has for people. People seeking healthcare might also need to understand and accept that on occasion, even if they want their health practitioner to practise in a person-centred way, there may be times when the needs of other clients are prioritised over theirs. It is difficult for people to always manage to do this. However, if clients have developed trust in their healthcare practitioners, it is more likely that they could understand the competing needs of other people accessing the same practitioners.

Recognising the centrality of clients in health practice involves balancing of different tensions in practice: caring and counting, self and other, wants and needs. Human relationships can be a mediating force/solution in such balancing. In research by one of the authors of this chapter (Tasker, 2013), a *mindful dialogues model* of practice for community-based physiotherapy was developed through dialogue with community-based physiotherapists, their clients and the carers and families associated with their healthcare. The iterative attitudes of being mindful, staying engaged and being responsive revealed through that research may be transferable to other contexts where the issue of balancing counting and caring requires practitioners to constantly remember to place the individual back at the heart of healthcare.

Relationships can be sustainable and provide health professionals and clients with positive human energy and goodwill (Frank, 2004). From a healthcare practitioner's perspective, positive relationships can give them the energy to keep going in the face of potential burnout. A positive healthcare relationship may also help clients, carers and families to frame constructive expectations for future healthcare interactions and empower them in their efforts to achieve both good healthcare outcomes and meaningful healthcare experiences.

HEALTH PRACTICE RELATIONSHIP CHAMPIONS

Retention of status quo practices comes under the powerful influence of practice traditions, healthcare systems and governance, individual healthcare practitioners and health service users on professional practices and consequently on health practice relationship formation. To foster the development of health practice relationships, explicit awareness of and ability to influence health and education contexts is needed. We contend that *health practice relationship champions* who privilege the development of health practitioner relationship capability are needed to bring about positive and sustainable change in health workplace cultures, healthcare systems and practice traditions.

The work of establishing and maintaining meaningful relationships often goes unacknowledged, as does the level of discomfort often experienced in *relational spaces*. In order to develop meaningful relationships, health practitioners need the freedom and capability to embrace the stories of others in a respectful and non-judgemental way. Across this book, stories of health practitioners negotiating the space between an ethic of caring and keeping a (professional) distance revealed this as an uncomfortable space where health practitioners may make decisions to comply, resist or subvert institutional expectations. Understanding and working with stakeholder expectations is complex and requires considerable effort. If we are to understand and engage with expectations in the contemporary landscape of increasing diversity and accountability, we need to take the context of the individual health practitioner, health service user and service provision into account. As an example of the influence of context, health practitioners working in health users' homes might develop closer relationships, often without even realising it.

The complexity of workplace relationships and the amount of work required to establish and maintain these relationships should not be underestimated. Practitioners and students undertake much work to establish and maintain these highly valued relationships. For example, maintaining positive relationships with other health practitioners often requires finding a balance between helping other practitioners complete their work and doing one's own work.

We argue that *health practice relationship champions* can serve in the first instance to develop exemplary health relationship practices. This can be achieved through deepening understanding of health practice relationships, critical self-appraisal, and commitment to undertaking the work involved in developing and sustaining meaningful health practice relationships. Being a *health practice relationship champion* requires action and capability beyond embracing and enacting exemplary health relationship practice in one's own practice. Change in health workplace and education cultures is needed, to effectively champion the privileging of health practice relationships. In this way, *health practice relationship champions* are agents of change. They must be able to question and critique current health and education practices that diminish health practice relationships, and to envision and bring into being new practices that nurture the development of practice relationship capabilities.

Within health contexts, paradigmatic perspectives are often entrenched and remain unnoticed because they are typically invisible and implicit. Yet they can be exposed by the way people act, think and talk about health practices and health service users. For example, health practitioners who claim that development of meaningful health practice relationships is not possible due to time constraints and competing clinical demands are demonstrating acceptance of organisational requirements for efficiency. In this instance, *health practice relationship champions* need to challenge both individual health practitioners in relation to their views and practices and health service management in relation to rules and regulations that diminish the establishment of authentic health practice relationships. Ethical courage is required to challenge other health practitioners' potentially judgemental attitudes in relation to some health service users. Raising perceived interpersonal shortcomings with peers can be an uncomfortable space and requires a high degree of sensitivity. However, diminished health practice relationship capabilities can be due to lack of awareness, education or experience, and health service users can ill afford to wait for health practitioners to develop these capabilities over time. Clients, carers and families increasingly expect person-centred health practice relationships, and this expectation may also act as an impetus for change and support for practitioners who champion such relationship development.

Being a *health practice relationship champion* requires the provision of support to colleagues as well as action and advocacy for conditions conducive to the development of meaningful health practice relationships. Thus *health practice relationship champions* require a reflexive awareness of the influence of the many dimensions of health contexts on their own practice and that of others, as well as the ability to creatively imagine ways to harness the power of existing spaces and to foster new spaces that facilitate the development of authentic health practice relationships.

CONCLUSION

People are central to all healthcare, whether they are clients, healthcare practitioners or others (e.g. managers) working within healthcare organisations. If clients are to remain at the centre of health practice, we have to recognise the paradoxes inherent in “person-centred” care, while also acknowledging the laudable aims of the policies that seek to incorporate the rights and humanity of the people who seek healthcare. If clients are to be at the forefront of healthcare, the processes of caring and counting must be entwined with health practice relationships. Individuals as well as systems can be active promoters of positive relationships that improve healthcare experiences and outcomes.

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27. HEALTHCARE SYSTEMS AND POLICIES

Individuals and communities are experiencing increasingly complex health issues which vary widely in different local contexts (World Health Organization (WHO), 2010). Healthcare systems are accordingly highly complex, interconnected and constantly changing, with reforms regularly implemented. The increasing costs of healthcare result in governments and healthcare organisations focusing on public cost containment, often reducing the healthcare workforce and increasing client numbers. These changes invariably impact on the time healthcare professionals have available to develop the collaborative client and colleague relationships which strongly and positively contribute to health outcomes and healthcare experiences. It is crucial that healthcare is perceived and realised with clear regard to this complexity, and that healthcare systems are led and managed in ways that are mindful that multifactorial relationships influence their delivery and outcomes of healthcare. Current national and international healthcare reforms are focused on delivery of healthcare that is “safe, person-centred, co-ordinated, collaborative, equitable, holistic, flexible and responsive” (Health Workforce Australia (HWA), 2012, p. 9). Implementation of healthcare services that meet these goals depends not only on the skills, attitudes and values of individual healthcare professionals but also on healthcare systems and organisations actively pursuing mechanisms and policies to promote such a person-centred approach.

As previous chapters in this book have identified, the development of therapeutic relationships/alliances between healthcare workers and their clients and family members is fundamental to achieving these HWA-identified outcomes. The development of effective working relationships between healthcare workers is also essential to afford a collaborative approach to the provision of individualised healthcare. The establishment of such relationships requires time and skill if healthcare workers are to demonstrate the essential skills, values and attitudes necessary to develop effective therapeutic alliances. Although it is acknowledged that many factors, including up-to-date equipment, information technology and physical resources, contribute to achieving optimal health outcomes for individuals and communities, the focus of this book is on healthcare relationships.

This book has provided compelling support from narratives, research and theoretical perspectives for the central importance of effective relationships between clients and healthcare professionals and of effective relationships between healthcare professionals, for positive health outcomes for clients and communities. In this chapter we argue that strong and effective leadership, supported by clinical and corporate governance at all levels within the healthcare system, is crucial to locate healthcare relationships in the foreground of healthcare practice.

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Healthcare systems at macro- and micro-levels need to develop, implement and evaluate policies that promote workplace cultures and environments that value this focus on positive professional relationships. Key components of these workplace cultures are collaborative teamwork, ethical and safe practice, ongoing learning and development of staff, people-focused healthcare environments, and research that engages with the complexity of healthcare practice relationships.

IMPORTANCE OF EFFECTIVE LEADERSHIP

Strong, effective leadership has a significant influence on productivity, workplace morale and workplace culture (WHO, 2010). Research has revealed the impact of different leadership styles, with recent research supporting transformational leadership as the preferred style in Western societies. Complexity leadership has also been posited as the most relevant approach in current circumstances (Weberg, 2012). Although definitions vary, key attributes of effective leaders include an ability to inspire a shared vision, leading by example, creativity, integrity, courage, and an ability to engage others to participate (Needham, 2008). Leaders of healthcare organisations need effective people-oriented skills, including interpersonal, communication, negotiation, motivation and delegation skills, in addition to financial management, technical expertise and other managerial skills (HWA, 2011b; Needham, 2008).

Political, organisational and team leadership are essential for the creation and maintenance of a workplace culture which fundamentally values clients and staff, promotes a collaborative client-focused approach, and engages with consumers, carers and communities in the provision of safe quality healthcare services (HWA, 2011b). Concurrently, different concepts of leadership need to be respected, including those of Indigenous peoples (HWA, 2011a & 2013). Professional and clinical leaders require organisational support to authentically and consistently realise their leadership role.

> The role of the leader (clinical or otherwise) is to facilitate and support new ways of working; to provide others with access to the knowledge and skills required for change; and to provide an environment where change happens and where the risks of change are acknowledged and minimised, (HWA, 2011b, p. 9)

Leadership capacity needs to be developed to lead and support workplace goals (HWA, 2012, 2013). Integrated leadership across all levels of the system is required, and the healthcare system needs to identify and support champions who will advocate for such mechanisms and policies (HWA, 2011a, b; WHO, 2010). Consistent with current research and recognition of the importance of effective leadership in healthcare systems, an Australian nationally agreed health leadership framework was developed in 2013. The goal of this framework, Health LEADS Australia, is: “leadership for a people-focused health system that is equitable, effective and sustainable” (HWA, 2013, p. 5). Leaders are required to demonstrate respect for others, engage in reflection and self-evaluation, effectively communicate a vision for the future, motivate others to share and implement this vision; and they are expected to be innovative, outcome-oriented and strategic.

REALISING ASPIRATIONS FOR SUPPORTIVE WORKPLACE CULTURES

A truly person-centred healthcare system which is responsive to individual differences and cultural diversity (HWA, 2012) needs a workplace culture that will support its aims. Successful healthcare workplace cultures espouse values of collaborative teamwork, ethical and safe practice, ongoing learning and staff development, supervision/mentoring, people-focused environments and relevant research. Strong and effective leadership and governance are essential for the establishment and implementation of a respectful working culture.

Collaborative Ways of Working

A growing evidence and research base indicates that collaboration between healthcare professionals is beneficial not only to individual clients but also to health workers, communities and systems (WHO, 2010). The WHO (2010) and HWA (2012) strongly support the implementation of a workplace culture that delivers collaborative practice at all levels in the healthcare system. Effective teamwork is vital within healthcare across all settings to ensure accurate sharing of information, effective decision making and appropriate client management (Leng & McCartney, 2012). Accordingly, and like other governments nationally and internationally, the New South Wales Ministry of Health, Australia (2013) has documented its responsibility to create a positive workplace culture with core values of collaboration, openness/transparency, respect and empowerment.

Throughout this book, the key importance of collaborative teamwork and the inclusion of clients in decision making about their healthcare have been discussed. The positive impact of developing respectful relationships/therapeutic alliances between clients and healthcare workers on health outcomes has been identified. The therapeutic alliances developed within those relationships provide clients with opportunities to make informed decisions and to collaborate with healthcare workers. Importantly, the development of relationships between clients and healthcare workers and the relationships between different healthcare workers requires time and skill. The WHO (2010, p. 28) has acknowledged that collaborative practice and effective teamwork require adequate occasions for "shared decision-making and routine team meetings. This enables health workers to decide on common goals and patient management plans, balance their individual and shared tasks, and negotiate shared resources". Leadership, policy documents, processes and behaviours shape the norms and culture that influence the provision of individualised, client-centred, collaborative best-practice healthcare at all levels of healthcare organisations (public health, organisation, team and individual).

> Structured information systems and processes, effective communication strategies, strong conflict resolution policies and regular dialogue among

> team and community members play an important role in establishing a good working culture. (WHO, 2010, p. 28)

The authors of this chapter support the view of the WHO (2010) that governments and organisations should not only develop governance models and strategic plans that embed client-centred, collaborative team-based practice in healthcare delivery but should also implement funding models to ensure that adequate staffing and physical resources are available to implement these models and plans. Collaboration with all key stakeholders, including consumers, is essential in the development, implementation and evaluation of these models and plans.

Ethical and Safe Practice

The dignity and safety of clients is prioritised when organisations and individuals have high standards of ethical, legal and professional practice (Gallagher & Hodge, 2012). The "ethical climate" of an organisation contributes strongly to the quality of healthcare for clients and their families. A positive ethical climate is characterised by open channels of communication, collaborative working relationships, access to adequate resources, managerial support and ongoing education. Ethical dilemmas can arise for health professionals as they provide services for clients and family members who are often facing "fundamental transitions in their lives and [who] may be highly vulnerable" (Leng & McCartney, 2012, p. 156). It is essential that these professionals have opportunities to discuss and resolve the moral distress that can arise in such situations. Without these opportunities, moral distress can result in poorer quality of care for clients, with staff members experiencing reduced job satisfaction and increased resignation rates, making the choice to leave their profession (Leng & McCartney, 2012, p. 156). Ethical and safe healthcare is enhanced when a collaborative approach to practice is used (WHO, 2010).

Governance mechanisms are required that establish, implement and evaluate system-wide standards to ensure ethical and safe healthcare for all clients (Australian Commission on Safety and Quality in Healthcare (ACS&QH), 2011; WHO, 2010). The ACS&QH (2011) further recommended embedding cultural safety and security into organisational systems and processes. It is also essential to enshrine learning and quality-improvement cultures (ACS&QH, 2011; Health Education & Training Institute (HETI), 2012c) in governance mechanisms at all levels in the healthcare system. This includes ongoing education and training of healthcare workers on all aspects of ethical and safe practice and a quality management approach to service provision.

Chapters in this book have raised and discussed some of the ethical dilemmas that can arise for health professionals working with clients and their families and some of the dilemmas that can arise at a system level. A supportive workplace culture, effective supervision/mentoring, and ongoing education for clinicians have been identified as essential to managing these dilemmas. The inclusion of ethical issues within entry-level education curricula for all healthcare professions is also crucial. Respectful, collaborative and culturally competent relationships which engender trust between health professionals, including managers, colleagues and supervisors/mentors, and between clinicians and clients are particularly influential when ethical dilemmas arise. The importance of health professionals demonstrating high-quality communication skills is essential for the establishment and maintenance of these relationships and the positive outcomes that ensue.

Continuing Professional Development for Client-Centred Practice

In some healthcare systems, clinical and corporate governance includes the education and training of healthcare workers to ensure that the workforce has the capacity and capability to provide effective and safe client-centred healthcare (ACS&QH, 2011; HETI, 2012c). All health professionals should engage in lifelong learning to ensure that they remain up-to-date with evidence and practice knowledge and remain competent to practise. This is both a professional requirement and, for many healthcare professions, a legislative requirement. HWA (2012, p. 8) further identified the importance of the ongoing development of the capacity and skill of an adaptable health workforce with the “requisite competencies and support that provides team-based and collaborative models of care”. Policy, regulation, funding and employment arrangements are required for ongoing learning to occur (HWA, 2012).

The utilisation of research findings and an evidence-based approach that places individual clients at the centre of service provision and places high priority on their experiences, choices and decisions are important for the ongoing education of the healthcare workforce. Recent research into the positive impact of therapeutic alliances between clients and healthcare workers and the core importance of effective communication in developing these alliances indicate other high priorities in healthcare worker education. The development of skills in the healthcare workforce of accessing national and international research findings and applying them to individual clients, with due consideration of contextual factors that can influence the translation of any research, is essential. Ongoing development of reflection, clinical reasoning and professional artistry is also required if the health workforce is to provide optimal service provision.

Embedding Supervision/Mentoring and Support into Health Professional Practice

Workplace cultures that include professional and line management supervision and mentoring and support for healthcare workers optimise healthcare service delivery. Supervision and mentoring can be integrated with continuing professional development. Some healthcare organisations have produced documents and learning programs to facilitate the implementation of effective supervision and mentoring of clinicians (HETI, 2012a, b).

A number of Australian and international healthcare systems have identified clinical supervision for all healthcare clinicians as best practice (Driscoll & O’Sullivan, 2007; HETI, 2012a). HETI (2012c) has documented a governance framework of education and training for allied health professionals which includes a guideline on clinical supervision. This framework aims to ensure that all therapists have access to high-quality clinical supervision from supervisors who have appropriate professional qualifications and expertise in supervision, that supervisors have access to relevant training, that supervision complies with national and state mandatory professional requirements and that managers and the organisation support the provision of effective supervision. This framework further identifies the need for organisations to collaboratively develop policies and guidelines with key stakeholders which embed supervision in the core business of the organisation. The focus and purpose of the HETI (2012c) best-practice governance framework is consistent with national and international literature on supervision and mentoring research (Driscoll & O'Sullivan, 2007; HETI, 2012a).

Throughout this book, chapters have provided evidence of the strong positive influence of effective supervision and mentoring on clinicians and subsequently on the health outcomes of their clients and communities. The importance of healthy working relationships that incorporate cultural safety between colleagues participating in supervision and mentoring has been explored, identifying also the time and expertise required for implementation and evaluation. The value of policies and funding to support supervision/mentoring has been identified.

Relationship Friendly Environments

The design of healthcare facilities and the physical spaces within these facilities can significantly enhance or detract from the implementation of effective client-centred and collaborative health practice. The design and organisation of physical healthcare environments can facilitate communication and promote effective collaboration as well as psychological and physical safety for clients and their families. Involving consumers and health workers in the design of physical healthcare spaces can also optimise their effectiveness. As expressed by the WHO (2010, p. 29), "most notably, physical space should not reflect a hierarchy of positions". The impact of healthcare facility design has been incorporated both explicitly and implicitly in this book, and the inclusion of consumer involvement in environmental considerations supported, along with the impact of location and design of healthcare facilities on relationships and clients accessing healthcare services. The authors of this chapter advocate leadership and governance to address the design of healthcare facilities with the goal of enhancing client outcomes and the healthcare relationships that strongly affect these outcomes.

Relevant and Responsive Research and Quality Management

Healthcare systems aim to provide quality and cost-effective healthcare services to the clients and communities for whom they are responsible. The complexity of the healthcare issues experienced by individuals and communities, increasing healthcare costs, changing priorities, community expectations and workforce requirements and new technologies and pharmaceuticals all impact on the delivery of services. The evaluation of constantly evolving healthcare services and systems using research and quality management methodologies is highly demanding. However, to assist governments in the provision of health care services, leaders at all levels in the healthcare system and clinicians need to optimise healthcare services to individuals and populations and to facilitate informed decision making using a variety of evaluation methodologies and research designs.

A commitment to support research and evaluation throughout the healthcare system across the sector and at government levels is crucial. Funding is essential to implement research and quality management projects and also to ensure consumer and clinician involvement/consultation in such projects. Funding is further required to ensure that health professionals who conduct research have adequate skills to do so and are appropriately skilled to access, interpret and apply research findings in reference to their individual clients and client groups and populations. Ongoing evaluation and research is needed into the nature and impact of healthcare relationships at all levels in the system, notably those between healthcare professionals and clients and between healthcare professionals.

CONCLUSION

Current national and international healthcare reforms and policies promote the notions of client-centred, collaborative, safe, culturally competent healthcare which is efficiently and effectively delivered. Throughout this book it is clear that the quality of healthcare relationships between healthcare workers and their clients and between healthcare workers is crucial to optimise such healthcare practice and outcomes for individual clients and communities.

> Health is about people. Beyond the glittering surface of modern technology, the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them. This trust is earned through a special blend of technical competence and service orientation, steered by ethical commitment and social accountability, which forms the essence of professional work. (Commission on Education of Health Professionals for the 21st Century, 2010, p. 5)

Strong and effective leadership at all levels in the healthcare system is essential for the development and implementation of governance structures and workplace cultures that are relevant to the local healthcare context and that support respectful professional relationships. These workplace cultures prioritise collaborative teamwork, ethical and safe practice, ongoing learning and development, supervision and mentoring, people-focused healthcare environments and research. We contend that, with adequate funding, such leadership, governance and workplace cultures will facilitate authentic healthcare relationships at the foreground of healthcare practice.

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NARELLE PATTON AND JOY HIGGS

28. IMPLICATIONS FOR HEALTH PROFESSIONAL EDUCATION

> I chose this program because I want to help people. I enjoy working with people.
>
> Pre-entry health practitioner student (first lecture)

> On my first placement I went to assess a patient. I found a very unwell, little old lady sitting up in bed. She was so tiny, fragile and *grey.* I didn't know people could be so unwell, so *grey.* It made me feel so sad. I will have to be stronger.
>
> First year pre-entry health practitioner student

> The procedure caused the patient pain. My supervisor said to continue. The procedure was necessary (for the patient's sake). Given the choice in the future, would I do that again? Yes, it was a good learning experience for me.
>
> Final year pre-entry health practitioner student

> I work on a busy ward. As a health practitioner I need to maintain a professional distance from my patients. I don't get too involved; it would be too traumatic. Anyway I don't have much time to chat to my patients, I have a lot of patients to treat, meetings to attend, medical notes to write, students to supervise and other administrative work to complete. Please don't ask me to do anything else.
>
> Health practitioner

> Connecting with people is the most rewarding part of my work. I am happy to bend the rules (e.g. taking more time) to create spaces where I can really be with my clients and genuinely help them. I am often motivated and inspired by their stories, their individual journeys. I am most fulfilled when I am working with clients I really know.
>
> Experienced health practitioner

The above vignettes are offered as an illustration of the critical influence of health practitioner education as well as health practice systems and cultures on shaping health practitioners' professional practice. In particular, the significant influence of

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these systems and contexts on relationships in practice is illuminated. While these vignettes represent different people, they also demonstrate a trajectory that many health practitioners experience from entering professional health practice education to becoming a professional health practitioner. Unfortunately, for some people during the journey of becoming a health practitioner the altruistic and caring desire to help and work *with* people that underpinned their original decision to enter a health practice profession can gradually be de-emphasised in the light of the need for self-protection and the competing demands of the education and healthcare systems. However, the final vignette illuminates the importance of authentic relationships in health practice and offers hope for more widespread and systematic development of constructive professional relationships.

Throughout this book, authors have portrayed the significant contribution of authentic and respectful health practice relationships to the achievement of positive health experiences and meaningful health outcomes for individuals requiring healthcare. Without collaboration, health services struggle to deliver effective, timely, safe and appropriate healthcare to the individuals with whom they work. As well, inherent tensions between professional practice (including relationships), healthcare expectations and the reality of healthcare contexts have been revealed. Given the critical (and often counterproductive) influence of contemporary healthcare contexts on healthcare in general and practice relationships in particular, a change in the culture within health workplaces is necessary to increase the positive experiences and outcomes for the individuals using them.

This change in culture can be promoted by service and professional leaders, by practitioners who remember their original motivation to help others in need of healthcare and through the actions of constructive *health practice relationship champions* (both overt leaders and quiet achievers) who engender positive and pervasive cultural change within health and education organisations and who foster positive health experiences and meaningful health outcomes for health service users. All these change agents would privilege professional and collaborative health practitioner relationships and challenge the dominance of technology, market-driven systems, politics and societal accountability trends. To engender such change, practitioners need to learn to recognise and privilege person-centred health practice relationship practice as an integral part of doing, knowing, being and becoming in health practice – and this should occur at all levels of health professional education and practice. This includes pre-entry formal education programs, as well as post-entry formal and informal education programs and activities such as professional association short courses, conferences, journal publications, tele-health, peer learning and mentoring and individual practitioner learning and reflection.

UNDERSTANDING HEALTH PRACTICE AND PRACTICE RELATIONSHIPS

A key challenge for educators is to continually reflect on the changing nature of practice, including practice relationships, in order to effectively educate students for both the reality of and optimal approaches to health practice. Importantly, education is not just a follower of (and a means of preparing students for) current practice, it is also a contributor to future practice, through creative and critical imagining, reflecting on and extending practice, researching and challenging current practice alternatives and learning from other practitioners.

The previous two chapters examined in depth the practice world. Here, we want to add a contextual exploration of practice relationships as a foundation for educational goals and practices. We contend that the health practice relationships model presented in Chapter 1 provides a valuable means of illuminating the complex manner in which these relationships are embedded in various practice contexts and embodied in many different players. This model privileges human aspects of health practice relationships through illumination of the many players involved as well as the influence of cultures and communities.

Importantly, this model also identifies many other contextual factors that shape our many health practice relationships, such as workforce systems and infrastructure that are capable of exerting a strong influence on the formation of health practice relationships. Contemporary health workplace systems often privilege the quantification of healthcare, particularly in relation to evidence of healthcare outcomes; this diminishes the importance of the immeasurable dimensions of practice, particularly the relational and experiential aspects of healthcare. In the face of unrelenting workplace pressures that often dehumanise health practices, it is important to keep health practice relationships central to health practices in order to enhance healthcare users' experiences and outcomes.

BECOMING A HEALTH PRACTICE RELATIONSHIP CHAMPION

The first steps on the journey to becoming a *health practice relationship champion or quiet achiever* require understanding of the importance of relationships in healthcare, critical self-appraisal of one's practice model and aspirations, and a willingness to undertake the work of developing authentic and meaningful health practice relationships. A deep and rich understanding of the complex, multidimensional and fluid nature of both health practice relationships and the contexts within which they occur, as portrayed throughout this book and in the health practice relationships model in Chapter 1, provides a vision of exemplary health relationship practice.

Beyond this understanding, meaningful health practice relationships demand critical self-appraisal, not only of professional skills and abilities (e.g. interpersonal and communication skills) but also of personal (and professional) values, judgements and practice models. Finally, meaningful health practice relationships require significant time, effort, goodwill and commitment from both practitioners and users of health services. Through a combination of knowledge, self-appraisal and commitment, meaningful health practice relationships can be created. It is only through development of exemplary health practice relationship capabilities in themselves that health practitioners can engender these capabilities in others and develop their own capabilities in building positive *health practice relationships.*

In previous chapters, the significant and often implicit influence of healthcare contexts, including professional and workplace standards, on the development of relationships with health service users and their families and carers was discussed. The resultant complexity and uniqueness of health practitioner relationships require health practitioners to engage in regular self-reflection and self-evaluation. Authentic health practice relationships require critical understanding of oneself (including professional and personal values and beliefs) and one's practice tradition (including implicit practice models) and the way these influence health practice relationships.

In this section we have portrayed capabilities central to authentic and meaningful health relationship practice. We argue that knowledge and critical self-appraisal skills, combined with ethical courage, are requisite to health practitioners' journeys of becoming practitioners who value health practice relationships and who seek to make them a positive and core ingredient in healthcare practice. We encourage all health practitioners to undertake this journey in both large and small ways, in order to promote meaningful health outcomes for health service users. In the next sections we move from self-directed professional development to engage with how pre- and post-entry education programs can contribute to the development of health practice relationship capability.

EDUCATION FOR HEALTH PRACTICE RELATIONSHIP CAPABILITY

Professional education programs and activities, both formal and informal, play an important role in shaping health practitioners' approaches to working within the human spaces of health and social care. Pre-entry students learn from the spoken and unspoken rhetoric and inherent values of their curricula as well as from their academic and practice role models. After graduation, peers (particularly those in the same boat of facing the reality shock typical in independent professional practice) and mentors can strongly influence the choices that practitioners make about their practice approaches, the professional identity they come to own and the strategies they use in realising their practice relationships. We need to remember that practitioners don't necessarily launch into their early years of professional practice with well-developed ethical frameworks and strategies for dealing with practice relationships and pressures. We argue that the focus on technical skill development and competency in pre- and post-entry education programs needs to be challenged. The focus needs to be extended to embrace the development of professional relationship capabilities that facilitate individual, person-centred, holistic healthcare practice that is rewarding for both practitioners and the individuals with whom they work. We should be educating people who work well with other people in their professional roles. This goal is inherent in the university strategy and curriculum model of Charles Sturt University (2013) which aims to develop "holistic, far-sighted people who help their communities grow and flourish" a goal reflected in the Wiradjuri[i] phrase, "*yindyamarra winhanga-nha*" ("*the wisdom of respectfully knowing how to live well in a world worth living in*").

Within pre-entry health programs, service learning represents a powerful teaching and learning strategy that provides opportunities for students to develop civic responsibility, to strengthen communities and nurture health practice relationship capability development. Service learning integrates meaningful community service with instruction and reflection to enrich learning experiences and encompasses the formation of reciprocal partnerships between students, communities and educators (McMenamin & McGrath, 2010). This experiential learning model provides a way of learning through experience and helps students to link their academic studies and knowledge with their learning about real-life problems in their communities.

Service learning offers a learning environment that promotes critical thinking and problem solving and requires students to practise ethical decision making (Housman, Meaney, Wilcox, & Cavazos, 2012). Importantly, service learning experiences provide students with the freedom to embrace other people's stories and interrogate their own biases, behaviours and pre-judgements. The inclusion of service learning in academic curricula provides a means to transform curricula and reaffirm the role of health professional education in the development of 21st century health practitioners capable of achieving optimal outcomes for those with whom they work, through the development of authentic and meaningful health practice relationships.

Throughout this book, authors have illuminated the work involved in establishing and maintaining meaningful health practice relationships and, in particular, the often uncomfortable space between caring and keeping a distance. Health practitioner education (at all levels) should facilitate the development of the ability to identify and negotiate this professional relationship space that lies between caring and keeping a distance. This requires development of practitioners' ability to privilege professional relationships in daily health practice work, which may include identification of when rules need to be bent or changed and when they need to be followed. It also requires practitioners to learn to deal with competing responsibilities and with complex ethical decisions.

In order to achieve highly customised healthcare for the individuals with whom they work, health practitioners need to be able to blend personal and professional aspects of their work. This education and development for health practitioners can be provided in the form of formal professional development courses, supervision (explicitly identified in performance management documentation), formal and informal mentoring, peer support, and perhaps counselling to assist in the development of integration strategies for dealing with the difficult emotional work entailed in professional lives.

In this section, we discussed the development of health practice relationship capabilities within both pre- and post-entry education. Service learning in pre-entry curricula was examined as a powerful example of practice-based education that contextualises learning and provides an authentic interface between academic learning experiences and health practice realities.

EDUCATION FOR CHANGING CLIENT INTERESTS AND CAPACITY

This book highlights the centrality of authentic relationships in healthcare practice. The health practice relationship model from Chapter 1 places people at the core of healthcare relationships. Client capability has been identified in the book as the ability of clients to influence and achieve healthcare outcomes that are meaningful to them. These outcomes encompass both the quality of their journeys as health service users and the end results and their potential to take self-management strategies into their future lives and wellbeing.

Client capability can be linked to health practitioners' capacity for narrative imagination, client education and client empowerment, all of which require practitioners to develop an ability to engage with clients in authentic dialogues. Enhancing client capacity requires health practitioner education (at all levels) that embraces development of the capacity to critically self-appraise one's assumptions and beliefs as well as the capacity to reach out and embrace the otherness of those with whom one works in a collaborative space of dialogue and professional relationships.

EDUCATING FOR CHANGING SYSTEM AND POLICY CONTEXTS

Importantly, the health practice relationship model presented in Chapter 1 and illustrated through many examples and arguments throughout the book highlights the significant influence of contextual factors on health practice relationships. Throughout this book the unremitting and often tacit influences of workplace systems and cultures on the development of health practice relationships have been emphasised. These influences range from spatial factors, including the physical arrangement of clinical spaces, through to cultural factors such as practice traditions including professional regulations and "the way things are done here". In contemporary healthcare contexts economic rationalistic practices often prevail, where the quantity of occasions of service is more highly valued than the quality of those services. In such environments, practitioners who value health practice relationships are required to privilege relationships in the face of unrelenting pressure to do otherwise.

Specifically, in relation to changing dominant system and policy contexts, health practitioner education (at all levels) is required to assist students and health practitioners to develop deep understanding of health practice contexts in all their complexity, as well as their significant potential to shape the development of health practice relationships. This can be achieved in undergraduate levels of education through provision of authentic case study scenarios in problem-based learning tutorials that emphasise the significant influence of contextual factors such as workplace systems on the development of health practice relationships. Students then need to be helped to develop the capability to challenge workplace practices that are deleterious to the quality of health practice relationships. This can be facilitated by role-plays where, with the guidance of experienced students and teachers, students undertake various roles within authentic clinical scenarios. These roles would include client, practitioner and manager. Workplace learning experiences also provide excellent opportunities for students to be supported to critique and challenge workplace practices.

Health practice relationship champions are also needed, to support health practitioners' (both pre- and post-entry) development of health practice relationship capabilities. This requires a high level of trust and the ability to assist health practitioners to critically reflect on their practice, including their attitudes and values. This is important because peer conversations have been identified as catalysts for critical thinking (Barnett, 1997; Brookfield, 1995). Apart from developing health practice relationship capabilities, these reflective conversations might also foster good team relations and guard against stress and burnout among health practitioners.

CONCLUSION

Throughout this book, the authors have privileged the humanity and diversity of health practice relationships. The character of these relationships established between multiple players in health, including healthcare users, healthcare practitioners, carers, service agencies, volunteers and so on, largely determines everyone's ability in relation to healthcare delivery and participation. The socialisation of health professionals in their pre- and post-entry education can influence their willingness to develop collaborative and ongoing practice relationships and partnerships. Health practitioner education (at all levels) is integral to supporting students and practitioners to develop relationship capabilities that enable them to flourish in the fluid, complex, unpredictable and challenging *relationship spaces* within contemporary health contexts.

Development of relationship capabilities will enhance practitioners' ability to achieve optimal health outcomes and experiences for health service users and for themselves, in a healthcare system dominated by calls for accountability, for monitoring of health practices, and by escalating complexity of health conditions. Health service users, whose health outcomes and wellbeing are at stake, are often vulnerable people who cannot afford to wait for practitioners to fine-tune their relationship skills over time. This book makes a compelling argument for the privileging of relationship capability in all pre- and post-entry education programs. The development of relationship capability should be considered at least as important as the development of competency in technical clinical skills. Given the powerful influence of health contexts on health practices, we argue that the development of good health practice relationships is a priority for systems, managers, practitioners and clients.

NOTE

[i] We acknowledge the culture and insight of Indigenous Australians.

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