THE CONCEPT OF COLLABORATION: A CRITICAL EXPLORATION OF THE CARE CONTINUUM

by

Robyn Penny

Bachelor of Health Science (Nursing)

Master of Family and Community Health

This thesis is submitted to fulfil the requirements for the degree of

Doctor of Philosophy

School of Nursing

Institute of Health and Biomedical Innovation
Queensland University of Technology
February 2015

Keywords

Child Health Nurse
Collaboration
Community Nursing
Constructionism
Care Continuum
Family-centred
Healthcare Policy
Midwife
Partnership
Professional Boundaries
Risk
Surveillance
Salient Identity
Uncertainty
Woman-centred

Abstract

The term collaboration has been used in healthcare for more than 65 years in various ways to refer to all forms of working together. To this day it is frequently cited in healthcare gaining traction because it is proffered as a solution to the complexity in systems. It is engaged politically and in practice to imply different interests coming together to negotiate freely around complexities and achieve common goals. Despite frequent references to the term, however, lack of clarity about what the term actually means exists. The purpose of this thesis was to explore in a way different to previous inquiry the concept of collaboration within a specific healthcare context. The research applied a critical framework to explore collaboration in the care continuum, a process of transition from hospital-based to community care. The exemplar for this work involved women with newborn babies who had spent more than 48 hours in a Special Care Nursery following birth and, having left hospital, engaged with a community child health service. Semi-structured interviews were undertaken with child health nurses working in the community setting, midwives working in the maternity setting, and women. The research was situated within a philosophical position of constructionism using a sociological framework drawing upon the works of Schutz, Mead, Blumer, Berger and Luckmann and Goffman. The framework focused on the process of knowledge and meaning construction that recognises the social and individual aspects of the world as one process and not separate entities. The interview data were analysed using four key processes; coding, constant comparison, memo-writing and theoretical sampling. The research involved two phases; the first of which was to explore the experience of collaboration as constructed by CHNs, midwives and women during interactions. Phase Two carried forward the key concepts from this analysis to explore the text of 25 political and professional documents to reveal convergent and divergent meanings around the concept.

The analysis determined that the meaning of collaboration was dynamic, fluid and ambiguous. The ambiguity reflected how collaboration served to obscure power relations and the complexities of social relations in healthcare that served different interests at different times. Findings around the construction and reconstruction of identity, knowledge and institutions by participants and as evident in policy documents reveal how healthcare consumers, professions and political interests have become socialised to the concept in such a way that allows what is defined as collaboration to proceed largely unquestioned. The research has implications for nursing and midwifery scholarship as well as political processes and healthcare consumers alike that caution against adopting an unquestioning attitude to what is proffered as collaboration. Rather, the research findings justify a more critical look at what is occurring, what is potentially hidden and how specific interests are served in the varied usages of the term.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

CHN Child Health Nurse

DOCs Department of Communities

GP General Practitioner

HREC Human Research Ethics Committee

NAFDIS Newborn and Family Drop-in Service
NEAF National Ethics Approval Form
NHMRC National Health and Medical Research Council
NICU Neonatal Intensive Care Unit

QUT Queensland University of Technology
QH Queensland Health

RGO Research Governance Officer

SCN Special Care Nursery
SSA Site Specific Assessment

UHREC University Human Research Ethics Committee
UK United Kingdom

WHO World Health Organisation

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief the thesis contains no material previously published or written by another person except where due reference is made.

Signature:

QUT Verified Signature

Date: 8th February 2015

Acknowledgements

There are many people to acknowledge in my journey to who I am grateful for their support and guidance.

To my family, who have endured with me and supported me, my husband Chris and daughter Alyson who I could not take this journey without; my best friends and true loves, thank you.

To the research participants who placed in me their trust and shared their time and experiences to make this happen, I thank you most sincerely.

To Associate Professor Carol Windsor a true professional and a clever minded mentor who provided the support I needed and instilled confidence to help extend myself.

To my associate supervisor Julie-Anne Carroll who has been full of kind and well placed words at times they were needed and in the provision of feedback on drafts of this work.

To my colleagues, in specific Drs Jan Pratt and Neil Wigg for their support and guidance in making this happen and providing the time I needed to undertake this work.

To all the friends I have made who helped to make the journey not so lonely, I thank you for the little things and kind words along the way that make it all worthwhile.

Chapter 1: Introducing the Research

1.1 INTRODUCTION

This research explored the concept of collaboration using a specific healthcare situation as an exemplar for this work. The exemplar was the care continuum, a process of transition from hospital-based to community care. In specific, the work explored the experiences of women with newborn babies who had spent more than 48 hours in a Special Care Nursery (SCN) and the child health nurses (CHNs), and midwives involved in the care continuum process. This first chapter introduces the reader to the research and includes an explanation of the background, context and purpose of the research. The chapter provides, first, a background to the study and addresses the significance of the research. Second, the chapter sets out the research context, questions and aims and explains how the researcher was situated within the research process. Finally, the chapter defines key terms and outlines the content and structure of the thesis.

1.2 RESEARCH BACKGROUND AND SIGNIFICANCE

The term collaboration is frequently cited in healthcare and has gained traction because it is proffered as a solution to complexity in healthcare systems. This is because the term implies different interests coming together to negotiate freely around complexities and achieve common goals. Despite frequent references to the term in political and professional circles a lack of clarity exists about what the term actually means.

Historically, the concept of collaboration entered healthcare literature as early as the 1940s in reference to the struggle between nursing and medicine as dominant interests. In the 1990s, the concept appeared in the competency discourse in nursing in Australia as part of the development of national competency standards for nursing performance (Grealish, 2012). On the international stage the World Health Organisation (WHO) has also focused on collaboration and collaborative action in strategic directions for healthcare and specifically in nursing and midwifery policy and practice (Health Professions Networks Nursing and Midwifery Office, 2010). The argument of the WHO is that the health workforce can be made "collaborative-practice ready" through interprofessional education (World Health Organisation, 2010, p. 7). Indeed, competencies that characterise an "ideal collaborative practitioner" and thereby inform interprofessional education have been developed (Canadian Interprofessional Health Collaborative, 2010, p. 6).

Contributing to the complexity in modern healthcare are different definitions of, and frameworks for, viewing health. For example, concerns about different morbidities and mortalities and conflicting views on what constitutes pregnancy, birth and parenting risk reflect a modern predilection with psychological, social, biomedical as well as political dimensions of healthcare. Broad social, environmental and economic factors are all identified as playing a part in the determinants of health (Australian Institute of Health and Welfare, 2012).

In the last decades of the 20th century conceptions of health changed whereby health became recognised as an item of consumption rather than a state of being (Easthope, 2004; Gould & Gould, 2001) and public health was being "reconfigured as 'self care' rather than as a collective responsibility for healthy social and physical environments" (Bella, 2010, p. 14). This marketisation process represented a shift in the patient relationship to an empowered consumer with personal responsibility for health and a reduced dependence upon traditional forms of healthcare provided by the state (Bella, 2010; Wyatt, Harris, & Wathen, 2010). In clinical settings such as child and family health and maternity care this shift translated as woman-centred and family-centred care, partnerships in care, choice and transparency in care relationships.

Yet a tension exists where consumerism is adopted politically to convey an impression of public participation, negotiation and democracy in planning and delivery of healthcare services that positions the healthcare user as active in a negotiated process (Mold, 2010). Consumerism is at once bound up with the notions of personal choice and autonomy in healthcare while limitations are placed upon this. For example, where healthcare reform is focused upon 'responsible' financial management that seeks to balance the public good with individual choice (Department of Health and Ageing, 2011; National Health and Hospitals Reform Commission, 2009; National Preventive Health Taskforce, 2009). The prevailing ideological view is a responsive healthcare system where consumers are reconstituted as active participants in decision-making around their healthcare

(National Health and Hospitals Reform Commission, 2009). Coordination and integration are invoked as the means for implementing these reforms to negotiate different interests, to overcome service duplication, and to address service gaps and inequalities (Department of Health and Ageing, 2011). Where political, professional and personal interests frequently diverge the language of collaboration is evoked as a mechanism to address fragmentation in the system caused by the conflicting interests.

Just as dialogues of empowerment and consumerism have become embedded in the narrative of responsibility (Bury & Taylor, 2008; Salmon & Hall, 2003; Wyatt, et al., 2010) collaboration has adopted different meanings in healthcare and can be engaged by different interests in different and sometimes conflicting ways. Indeed, the language of collaboration permeates much of healthcare despite an absence of clarity. An example is a 2008 report commissioned by the Australian Research Alliance for Children and Youth (The Allen Consulting Group, 2008) that focused on the shift of the child protection system in Australia from a tertiary dominated to prevention focused model. The report refers to collaboration more than 100 times using various terms such as collaborative strategies, collaborative approaches, collaborative models, collaborative relationships, collaborative processes and collaborative systems all of which were engaged around child protection reform without being clearly defined. The conclusion was that because systems were complex, collaboration as "rocket science" was needed (The Allen Consulting Group, 2008, p. 13). Yet where the term is clearly defined and ensconced in legislation and practice guidelines this implies regulation and clear demarcation of boundaries between professions that belies a freely negotiated relationship. This is how the term has been applied to 'collaborative arrangements' for midwives to practice with medical practitioners around the care of women so that the conditions for entering upon such arrangements are clearly defined (Australian Medical Association, 2010; Commonwealth of Australia, 2010).

At other times, appeals to collaboration occur when crises or concerns arise in healthcare. This is because change implies instability and collaboration is evoked as a means for reinstituting order. Since collaboration can be used to convey an impression of order the term becomes useful in the policy process. The assumption is that if people work together complexity will diminish and stability will be restored.

Yet what is known is that a plethora of research has generated different views on the understanding of collaboration and so the notion of order denies the reality of negotiation with a complex, pluralistic society.

In addition, the individualisation of healthcare that positions healthcare professionals, alongside consumers as experts and the central focus of care, conflicts with how professionals identify as experts through unique knowledge and how governments can enact authority in the public interest. Specialisation and the division of labour that defines healthcare services contribute to the conflict. This situation reflects the ongoing transformation of the concept of collaboration in terms of meaning and application that warrants further exploration. This research seeks to gain an understanding of the term by exploring the concept in a specific healthcare situation and in a different way to previous inquiry. This context will now be elaborated.

1.3 THE RESEARCH CONTEXT, QUESTIONS AND AIMS

The various permutations noted above underpinned the current research and the ways in which the research participants and policy-making conceived of and practiced collaboration. The concept was explored using the care continuum for women and their newborns as they transitioned from one healthcare setting to another. The exemplar for this work involved women with newborn babies that had spent more than 48 hours in a SCN following birth and, having left hospital, engaged with a community child health service. The focus on this context enabled a range of viewpoints within a particular healthcare situation to be available as the basis for analysis that would capture the meaning of collaboration.

The organisational contexts of the SCN and the community health services were not the focus of the research; rather the focus was on the social processes that characterised the interactions as women with newborns transitioned between the two healthcare settings. The SCN was chosen because a SCN admission extends the hospital stay for newborns; involves greater opportunities for interaction between CHNs, midwives and women, and most often results in direct communication of information between hospital and community health services to support women after hospital discharge. This can be particularly so where women, their babies and families, have additional needs or are vulnerable to poorer outcomes as a result of the circumstances contributing to the SCN admission.

Two phases to the research expanded the context and increased the interpretive field. The first phase explored the experiences of CHNs, midwives and women within the transition process. Taking this further, the second phase allowed the key theoretical ideas established in phase one to provide a framework for analysis of a sample of key policy documents in generating an understanding of contested and convergent meanings around collaboration. As such, policy documents in the area of child and family health, midwifery, nursing and government provided accounts of collaboration that reflected different political, professional and organisational interests to those elevated in interactions between the participants and researcher.

The two research questions that shaped this inquiry were:

- How do midwives, CHNs and women construct the concept of collaboration within the care continuum between a maternity and a community child health setting?
- How do policy documents construct the concept of collaboration?

The research aims were to:

- explore the experiences of CHNs, midwives and women as they negotiated the transition between hospital and community care when newborns had spent more than 48 hours in a SCN;
- critically explore the meaning of collaboration within the care continuum between SCN care and community care;
- analyse the text of current political and professional documents through the lens of collaboration as it was constructed in the care continuum; and
- generate theoretical insights into the concept of collaboration in the specific healthcare situation.

1.4 THEORETICAL POSITION AND METHODS

The philosophical position of constructionism adopted in this research focuses on understanding the processes of meaning construction, how people interpret, define and construct situations to arrive at meaning, how this shapes actions and how this in turn shapes the world. The position was vital in understanding the object of inquiry because it recognises that interaction and context are significant to meaning, not one more than the other. In other words, there are always subjective and individual dimensions to all that is social and such is the concept of collaboration.

The research represents a divergence from previous work on the object of inquiry. Following in the footsteps of theorists such as Schutz (Wagner, 1970), Mead (1934), Blumer (1966), Berger and Luckmann (1966) and Goffman (1967, 1974), it is argued that much can be learned when we engage a social framework that recognises human beings as having selves. In essence, as social actors, people construct their worlds. The focus here is on social process, how and why people construct their worlds in certain ways and what this comes to mean for people. Positioning people as active agents in creating their worlds, rather than merely responding to an external world is fundamental to the social view of this thesis. Furthermore, the research position views policy text just as much a part of the social world as people. Thus the research perspective considers how the things we assume as ‘natural’ in the world are actually cultural artefacts created through human interaction (O'Leary, 2007). This moves to a space where knowledge and meaning can be seen as dynamic and in turn reflective of current social realities.

A contemporary attitude toward data that is philosophically consistent with the epistemological position of constructionism was adopted in this research. Although the appearance of the names of Glaser and Strauss may invoke expectations of an essentialist adherence to the laws of grounded theory, it is stated at the outset that this was not a grounded theory study. The research set aside what Chamberlain (1999) refers to as a fundamentalism in grounded theory works to draw on appropriate and useful key methods as set out in the seminal work of Glaser and Strauss (1967), advances upon this approach by Glaser (1978) and more recent developments toward a constructionist position (Charmaz, 2006, 2008). The resultant analytically flexible process involved levels of coding, constant comparison, memo-writing and theoretical sampling to construct a critical view of the concept of collaboration as it materialised in the particular research setting.

1.5 SITUATING SELF IN THE RESEARCH SITUATION

The position adopted in this research diverges from previous work in the area by acknowledging that the researcher is just as much a part of the social world as the participants and becomes, therefore, part of the research process. This is because the philosophical position of constructionism contests the view that researchers, as social beings, can leave behind experience and knowledge completely or even in part. Rather than maintaining a veneer of neutrality, aspects of self are engaged productively and responsibly in the research process and should be openly acknowledged. In other words, it is argued that recognising the self in research is merely making explicit the presence of the researcher that objective approaches work hard to conceal. The key is to use one's experience and knowledge to advantage in research through thoughtful application of the self and using a philosophical position and methods that demonstrate how the position carries through the work. Mead (1934) indicated that self is an important social object; where self is both subject and object and people can therefore position themselves in ways that are most useful in interactions. Drawing on this premise, the aim of the researcher was to assume a position throughout data collection, data analysis and theorising that used experience and knowledge to 'sensitise self' in the research process. Through thoughtful reflexivity, or a preoccupation with questioning, this may be achieved.

The researcher was a member of the nursing and midwifery communities working within the research setting. There were aspects of this positioning that enabled a reflective balance to be negotiated. For example, the researcher has worked many years in different contexts, both urban and rural, that were very different to the current research context. The researcher has also engaged in academic and research activities throughout Queensland. Previous practice and research interests have centred on psychological frameworks to view the world. This research diverged from the psychological roots of family practice to embrace more fully a sociological world view. This meant that a lot more was required of the researcher to develop in a different way the interpretive repertoire required to balance 'insider' and 'outsider' positions.

Constructing meaning necessitates thoughtful and informed interpretation but also a critical approach to the object of inquiry. The research aim was to adopt an interpretive scheme that remained alert to multiple realities around the object of inquiry while actively seeking to identify *what*, *how* and *why* meanings and actions on collaboration were constructed (Charmaz, 2006, 2008; Gubrium & Holstein, 2008). Staying alert to different realities involves reflexivity or that which has been described as a researcher's "self scrutiny" (Charmaz, 2006, p. 188). This refers to the process of interaction within and between researcher, participants and data (Etherington, 2004). Because interpretations are continually being made during inquiry the researcher was required to reflect constantly on situations. The key predilection was to 'focus on process' as the key, asking questions such as: what is going on here; and what function does (this) perform? Attention was paid to as many dimensions of situations as possible without letting one dominate and this was achieved by persistently pondering upon the premises for thought and observations and the use of language (Alvesson & Skoldberg, 2009). This process raises consciousness about both what is being constructed and decisions made about what earns its way into a research situation. A reflexive loop is required where the researcher maintains self-reference while contextually recognising the relationships in which knowing activities are embedded by reaching out to different data to make sense of a situation.

The researcher became embedded in and responsive to the research situation which had implications for how prior knowledge and experience were engaged. The assumption of a critical stance meant critiquing all that appeared and being alert for all possible standpoints in interpreting and understanding the research situation. It was important to be aware of ideas that came readily about data and how knowledge at hand can easily be imposed upon situations while careful deliberation of other possibilities ignored. The aim was to understand how personal, social and cultural contexts may be impacting on the choices and interpretations made in the research situation (Etherington, 2004). It meant also making choices and interpretations open so that others could engage with the position taken. While it is acknowledged that researchers cannot fully divorce themselves from the social past and present, awareness of influences facilitates reflexivity.

The alternate view on situating self, that is as an objective observer separated from what is being researched, was not useful in the research and was challenged as a valid stance. Adopting a view of self apart from the research encourages the researcher to focus on what is seen as objective truth in situations. This risks situating inquiry at the descriptive level as one’s own investment in the interpretive process is marginalised to preserve a “facade of objective neutrality” (Bolam, Gleeson, & Murphy, 2003, para. 19). Rather, the position adopted here was that reflexive research engages a certain scepticism that looks beyond the surface to generate knowledge and to open up understanding rather than to establish truths (Alvesson & Skoldberg, 2009). The fundamental premise thus adopted was to situate the self in the research reflexively. A reflective approach was engendered by remaining focused on processes, by critically exploring situations and finally by engaging in thoughtful conversations with research participants, colleagues and supervisors. The issue of positionality on data is further elaborated in Chapter Four of this thesis.

1.6 CONCEPTUAL DEFINITION OF TERMS

The researcher was joined in this research by women, CHNs and midwives. The research aimed to capture the social processes as participants came together and to elicit the meaning of the concept of collaboration as reflected in interactions. Because the concepts of positioning and identity were pivotal to understanding the situation some clarity is provided around the participant groups and the context.

The care continuum refers to the social processes that characterised interactions as women with newborns transitioned between two healthcare settings. While this does not denote a specific temporal or spatial event, the aim was to capture interactions between all participant groups during the first few weeks through hospital discharge and engagement in community care. In particular, the work explored the experiences of women with newborn babies who had spent more than 48 hours in a SCN and the CHNs, and midwives involved in the care continuum process. While the care continuum was the social context for this inquiry, CHNs, midwives and women at times drew attention to issues around pregnancy and birthing that were perceived as important dimensions of collaboration and as such these were included as data.

The Special Care Nursery (SCN) provided services for babies who were born moderately preterm and/or low birthweight or required care for problems arising in the neonatal period. Although the term Neonatal Nursery sometimes is used to denote this care environment, in this research the term SCN was used as this was the language of midwives and CHNs. All women participants had babies who had spent more than 48 hours in a SCN.

The midwives and CHNs in the research practiced in the hospital and community settings that encompassed the care continuum. The social interactions remained the focus of this research. The following provide some conceptual clarity around the roles and qualifications of CHNs and midwives. More specific detail of research participants is included in Chapter Four of this thesis.

A child health nurse (CHN) is a registered nurse with postgraduate qualifications and experience in child and family health nursing working in various settings (Australian Health Ministers' Advisory Council, 2011). A number of CHNs also hold midwifery qualifications as was the case with a small number of CHNs in this research. The CHN participants were referred to as such if their employed role was in the community child health context. The CHN role has various nomenclatures throughout Australian states such as Maternal and Child Health Nurse, Child and Youth Health Nurse and Child and Family Health Nurse. Indeed, throughout Queensland references to the role vary. For the purposes of this research the term CHN was applied as this was the language of the participants. The role equates to the Health Visitor in the UK and the Plunkett Nurse in New Zealand and is similar to a Public Health Nurse in parts of the United States of America and Canada. CHNs provide primary health care services to children, young people and their families in the community focused on health promotion, early intervention and prevention and mainly in child health clinics and through outreach home visiting programs. The CHN participants in the research were all employed within government funded child health services in the community.

A midwife is a person who has successfully completed a prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery (Nursing and Midwifery Board of Australia, 2006a). Midwives practise in the home, community, hospitals and clinics to provide midwifery care to women and infants during pregnancy, birth and the early weeks following birth (six weeks after the baby is born) (Australian College of Midwives, 2013; Nursing and Midwifery Board of Australia, 2008a). For the purposes of this research midwife participants were all employed within government funded maternity hospitals. Some of the midwives worked in different roles within the hospitals including SCN and ambulatory care. For clarity the term midwife was used despite the adoption of different roles.

A nurse refers to a person who is registered to practise nursing in Australia. For the purposes of this research this included nurses working in speciality areas of hospitals, such as SCNs, with specific knowledge and skills related to the specialist roles. All of the nurses working in the SCN were midwives, although this role is often identified as a Neonatal Nurse. The term is also used more broadly in the research to refer to general statements about the nursing profession and to reflect language used by participants, in policy documents and literature.

In a similar way to the above, the term patient was used more generally in the research where it reflected the language of participants, policy documents and literature. The term ‘client’ is often preferred by CHNs.

A professional is any healthcare professional with knowledge and skills to provide care to women, babies and families in the context of this research. The term also applies within the broader healthcare and policy context. For the purposes of this research the term is applied collectively unless reference is being made to specific professions.

Policy in the context of the research is defined broadly as statements of intention or action made by public, private and voluntary organisations that have an impact on health and the healthcare system (Palmer & Short, 2010).

1.7 THESIS OUTLINE

There are nine chapters to this thesis. The following chapter, Chapter Two, presents a contextual review of the literature. The review is not intended to be a definitive statement about what knowledge exists on the concept of collaboration as this diverges from the philosophical position adopted. Rather, this chapter presents research knowledge on collaboration to reveal assumptions that have previously been drawn on the concept. The chapter includes a review of the concept of collaboration specific to the care continuum relevant to maternity and child health care.

Chapter Three situates the research philosophically and argues the theoretical points that are carried through to the analysis of data. Drawing on the works of Schutz, Mead, Blumer, Berger and Luckmann, and Goffman the framework focuses on the process of knowledge and meaning construction that recognises the social and individual aspects of the world as one process and not separate entities.

The philosophical position is carried through to the methods as detailed and justified in Chapter Four. This chapter demonstrates how the philosophical position of constructionism is consistent with an interpretive domain that draws upon four key processes from the broad grounded theory tradition. Chapter Four also explains the research participant and policy sampling, data collection process and elaborates on the detail of the data analysis. The chapter concludes with an overview of the ethical considerations and health and safety issues pivotal in sound ethical and safe research practice.

Chapters Five through to Seven outline the three key conceptual ideas constructed through the research analysis process. Key understandings around identity, knowledge and institutions are expounded upon as dimensions of the concept of collaboration. The key conceptualisations point to ambiguities and complexities surrounding collaboration.

The conceptual findings of the above three chapters provided the frame for an analysis of key policy documents in the area of healthcare and the outcomes are articulated in Chapter Eight. Professional and political positions on collaboration were explored using the key concepts to depict areas of convergent and divergent meaning.

Finally, the thesis concludes with Chapter Nine, drawing together the research process and arguing how the concept of collaboration performs an important social function in healthcare situations such as the one under study. This final chapter poses the implications of the findings for healthcare policy and the role that CHNs, midwives and consumers have in the policy process. The chapter closes with some comments on the research process.

As noted above, the purpose of the following chapter is to contextualise the research through engagement with a broad range of literature that is directly relevant to the focus of inquiry. The chapter situates collaboration historically, professionally, politically and theoretically.

Chapter 2: Contextual Review of Literature

2.1 INTRODUCTION

The purpose of this chapter is to explore ways in which the concept of collaboration has been represented in the literature. The function of a contextual review of literature in qualitative enquiry is not to present an exhaustive or systematic account of the topic but rather to set the scene and focus for the research, orientate the reader and provide some broad ideas for engaging during data analysis. Engagement with the literature reveals the assumptions that underpin the concept of collaboration. The assumptions informed the research questions and associated ideas acted as sensitising concepts in the analysis of data. This chapter first provides a brief historical background as the context for current understandings on the concept of collaboration. This is followed by an exploration of how the concept of collaboration has been framed in the care continuum and in maternity and child health care. The chapter concludes with some final comments on the concept of collaboration outlined in the contextual review.

2.2 SCHISM OR COLLABORATION: REFLECTIONS OF THE PAST

Early ideas on the concept of collaboration appeared from the 1940s in the nursing literature. The editorial in *The American Journal of Nursing* of 1947 drew attention to collaboration in reference to the struggle between medicine and nursing as dominant interests in healthcare ("Schism or collaboration?," 1947). Through to the 1960s discussions continued to focus on how a growth in scientific knowledge and specialty areas in health affected the working relationships between nurses, doctors and patients (Pratt, 1965). The conclusion was that changes gave rise to blurred distinctions that required coordination between nurse and doctor as team-players (Pratt, 1965). The patient perspective entered the dialogue on collaboration with reference to how divisions in care left patients feeling “fragmentized” (Malone, 1964, p. 39). In the latter part of the 1970s collaboration appeared in the literature with reference to other healthcare professions such as social work (Mailick & Jordan, 1977). Mailick and Jordan (1977) outlined three models of collaboration where roles could be decided upon according to which occupational groups would be crucial for a patient's survival.

There was a persistent focus on nurses and physicians working in teams during the 1980s and the representation of patients as healthcare 'consumers'(Weiss, 1985). A link between collaboration and patient outcomes was being made despite the lack of a generally accepted definition of the term (Baggs & Schmitt, 1988). In the same era, Styles (1984) reiterated the lack of clarity as the rationale for developing a framework for collaboration as a hierarchy of elements, akin to Maslow's proposal on human need. Empirical studies tested the effects of collaboration (Koerner, Cohen, & Armstrong, 1985; Temkin-Greener, 1983; Weiss, 1985); although Koerner and colleagues concluded that collaborative models did not demonstrate a significant impact on patient perceived quality of care when compared to traditional models of practice. Weiss (1985) took a different approach in assessing how discourse strategies that were encouraged between nurses, physicians and consumers influenced collaborative beliefs and behaviours. The conclusions of this study were that language appeared to reinforce professional power structures rather than foster collaborative values among participants (Weiss, 1985).

From the 1970s to the 1990s the conversation had shifted from the concept of 'team nursing' (Schlotfeldt, 1965; Williams, 1964) to multidisciplinary and interdisciplinary teamwork involving various health professionals (Given & Simmons, 1977). For example, the concept of joint education was elevated as a means of creating understanding between professions, overcoming the socialisation of healthcare professions to limited perspectives on situations and progressing collaboration in practice (Devereux, 1981; Given & Simmons, 1977). One study of note called into question the very idea of interprofessional teamwork because different individual and professional objectives existed and gave rise to conflict over decision-making (Temkin-Greener, 1983). The use of the term teamwork gave the impression of collaboration while something quite different was occurring (Temkin-Greener, 1983). The authors found that the individual and professional goals of nurses and nursing and physicians and medicine, vis-á-vis 'teamwork' were disparate and conflicting (Temkin-Greener, 1983). The conclusion was that the terms interprofessional and interdisciplinary teamwork were accepted without question and this acceptance concealed conflicts. During this period issues of concern in the area of child health and midwifery were shaping professional views on healthcare including social and mental health perspectives on maternal health. Dialogue continued to focus on professional tensions around collaborative working arrangements between midwives, obstetricians and general practitioners.

From the 1990s on, the concept of inter-professional education appeared on the global agenda associated with the idea that people could be taught how to work together and could learn collaboration (World Health Organisation, 2010) although there was no evidence that learning enhanced collaboration (Gittell, Godfrey, & Thistlethwaite, 2013). Other related concepts on collaboration that appeared included integration, integrated care and joined-up care (Bell, Kinder, & Huby, 2008; Frost, 2005).

A more recent focus in maternity care has been on collaboration to clarify professional boundaries as evident in three consecutive maternity service reviews conducted between 2004 and 2007 in Australian states and territories (Department of Health and Ageing, 2009; Hirst, 2005; McIntyre, Francis, & Chapman, 2012). The focus was on achieving higher quality healthcare with finite financial resources. A concurrent influence was the promotion of individual moral responsibility for health through access to knowledge, self-surveillance, self-help and risk assessment (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). There is a continued call for greater clarity on the concept of collaboration in response to an increasingly specialised healthcare workforce, limitations on the healthcare purse and divergent viewpoints on political, professional and consumer roles and responsibilities (Lane, 2012b). The following section examines assumptions underpinning the concept that will inform the research.

2.3 ASSUMPTIONS ON THE CONCEPT OF COLLABORATION

Collaboration has been described in its simplest form as working together (Baggs & Schmitt, 1988; Meads, Ashcroft, Barr, Scott, & Wild, 2005; Scott, 2005). Falling short of complete integration, collaboration focuses on players having a shared goal or activity (Johnson, Zorn, Kai Yung Tam, Lamontagne, & Johnson, 2003; Meads, et al., 2005; Stapleton, 1998; van Eyk & Baum, 2002). The meanings attributed to collaboration, however, vary considerably.

Early work on collaboration took a generic view of the concept as, for example, did Henneman and colleagues (1995) in their concept analysis. The analysis focused on supporting literature and depicted collaboration as occurring between health professionals and primarily nurses and doctors in the hospital setting. The attributes of collaboration were, for the most part, around sharing such as shared planning, decision-making, goals and common products and responsibility and power based on knowledge and expertise rather than role or title (Henneman, et al., 1995). Factors found to influence whether or not collaboration had occurred included individual readiness, accepting one's own role and expertise, recognising boundaries, respect and trust, team orientation, leadership and organisational support.

DÁmour, Ferrada-Videla, Martin-Rodriguez and Beaulieu (2005) identified similar issues in relation to collaboration in their literature review including sharing, partnership, interdependency, process and power. The authors noted that what seemed to limit understanding of collaboration was the diversity of ways it was conceptualised and influenced, the lack of links with outputs and the limited patient perspective (DÁmour, et al., 2005). Gaps in knowledge around the concept and attempts to link it with quality outcomes persisted throughout the latter part of the 20th century because the studies of this time were derived from what was already known which hindered the progress on understanding collaboration (Schmitt, 2001). In particular, Schmitt drew attention to the lack of qualitative research on collaboration and argued the necessity to explore the concept as a process rather than as dichotomous, that is, a present or absent variable.

In a more recent concept analysis of collaboration, Petri (2010) noted how her initial assumptions about the concept did not take into account the diverse range of ways the term could be been applied in healthcare including interactions among health professionals, between health professionals and patients and between organisations and institutions. The concept analysis was therefore confined to 'interdisciplinary collaboration', that is, collaboration among health professionals from different disciplines to delineate the focus. Petri found the most commonly referred to elements of successful interdisciplinary collaboration amongst health professionals were interprofessional education, role awareness, interpersonal relationship skills, deliberate action and individual and organisational support. Attributes most often used in conjunction with collaboration were a 'problem-focused' process; shared objectives, responsibility, decision-making and power; and working together (Petri, 2010). Petri drew attention to the inconsistent use of the term and how the elements of the concept were frequently blurred.

Exploration of collaborative care has continued to emphasise reciprocal relationships in healthcare while research has progressed more slowly on the patient perspective (DÁmour, et al., 2005; DÁmour, Goulet, Ladabie, San Martin-Rodriguez, & Pineault, 2008). An exception is a recent study in Australia (Cheong, Armour, & Bosnic-Anticevich, 2013) that explored the patient perspective of multidisciplinary collaboration around the management of asthma. This study indicated how patients had little expectation that healthcare professionals would collaborate or interact. Rather, the preference of patients was for self-management and consultation with sole healthcare providers. The majority of patients in this study saw themselves as good 'self managers' irrespective of the severity of disease. Further, patients expressed limited understanding of the roles of different healthcare professionals (Cheong, et al., 2013).

There is some consensus that the key to collaboration rests in anchoring goals, objectives, decision-making and information in a shared value base. The idea of a common goal for collaboration is prevalent in discussions about maternity care as women-centred (Heatley & Kruske, 2011; Murray-Davis, Marshall, & Gordon, 2011) and family-centred (Katz, 2012). Similarly, for child and family health the rationale for adopting family-centred care rests on the notion of negotiated care around the needs of the family (Coyne, O'Neill, Murphy, Costello, & O'Shea, 2011; Shields, 2010). Family-centred practice redefines the entire family as the unit of attention so that care focuses on informed choices made by the family (Allen & Petr, 1998). Debate exists, however, around whether services working primarily with adult clients can work holistically and adopt family-centred practice (Devaney, 2008; Scott, 2005). For example, tension exists in child and family work due to conflicting interpretations of advocacy. This includes differences in viewpoints on what the best interests of the child might be, the right balance between individual and public responsibility for the wellbeing of children, and complex debates around the rights of children and parents (Scott, 2005; Shonkoff, 2000). Practitioners who are encouraged to work across traditional boundaries may perceive philosophical differences as challenges to professional roles. Role blurring or role broadening can challenge professional identity and thus collaborative work (Scott, 2005, 2009).

Responsibility is a common theme in discourse around collaboration and is also used interchangeably with accountability. Assumptions include how responsibility should be shared or jointly taken on by health professionals (Heatley & Kruske, 2011). Other references are made to the role that women play in the distribution of responsibility. A common element of many studies was how clear roles and responsibilities contributed to collaborative practice. Suter and colleagues (2009) highlighted, from a qualitative study, that understanding and appreciating roles and responsibilities was significant to collaborative practice. Although achieving this was dependent upon communication, negotiation and consensus, many struggled with this in everyday practice.

A different perspective on collaboration concerns the structural levels in social systems. Collaboration is described in relation to factors external to organisations (systemic or strategic), factors within organisations (organisational and operational) and individual (interactional and relational) factors (Lishman, 1983; Meads, et al., 2005; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Systemic or strategic level factors that influence collaboration include issues embedded in social, cultural, educational and professional systems. These include policy since policy processes determine how priorities are decided and resources allocated. Examples of legal and political influences on collaboration refer to mandatory reporting of child abuse and neglect and privacy legislation that impact information sharing, and also categorical funding models that encourage single input services and competition for scarce resources (Scott, 2009).

Organisational or operational level factors impacting collaboration include workloads, service delivery models, performance indicators, professional autonomy and risk-averse cultures as well as prevailing organisational cultures (Scott, 2009). Interactional or relational level factors are the willingness to collaborate, trust, mutual respect and inter-professional and personal communication (Meads, et al., 2005; San Martin-Rodriguez, et al., 2005).

Differences in opinions about collaborative relationships indicate how some professions focus more on trust and respect while others emphasise accountability (Reiger & Lane, 2009). Reiger and Lane (2009) found that while a deal of rhetoric existed around service delivery in terms of teams and multidisciplinary collaboration, basic interpersonal qualities were necessary prerequisites for effective interaction. The existence of personal qualities and motivating factors suggest that collaboration is considered by some as a personal decision (Meads, et al., 2005). Indeed concurrent dialogue goes further to suggest that sharing and working collaboratively involves a willingness to take personal risks (Rushmer & Pallis, 2002).

Herbert and colleagues (2007) looked at the relational aspects of collaboration from the perspective of eight professionals from nursing, medicine, occupational therapy, physical therapy and massage therapy to elicit why people choose to practice collaboratively. The authors concluded that many factors influenced individuals to think and act in collaborative ways including childhood experiences, social norms, role models and mentors, and being exposed to previous positive or negative collaborative experiences. Skills that midwives have linked with collaboration such as the ability to reflect on practice, confidence, communication and respect for others have been argued as individual behaviours rather than competencies around collaboration (Murray-Davis, et al., 2011). Yet competencies and capabilities of individuals are seen as the real scaffolding for collaboration when it is argued that characteristics of collaborators differ from the norm (Keast & Mandell, 2011a). Others see that collaboration is fundamentally about what occurs between individuals (Stapleton, 1998). The argument of Keast and Mandell (2011a) on this is that some people inherently possess the necessary characteristics for collaboration while others can learn the skills if willing to step outside personal comfort zones. Other authors concur that attitude and personality are keys to collaboration but skills can also, to an extent, be taught and practiced (Stefaniak, 1998).

A further study that explored the experiences of practitioners and service users using a phenomenological approach, focused on the process involved in collaboration (Nicholson, Artz, & Armitage, 2000). A key finding of this work was that no single model of collaborative practice could apply to all multidisciplinary endeavours. Further, the role of specific disciplines appeared to be less predominant in the collaborative process than the commitment of individuals in the process (Nicholson, et al., 2000).

A literature review on the impact of service integration for pregnant and parenting women in Australia and collaboration between midwives, CHNs and General Practitioners (GPs) also concluded that there are variable outcomes depending on whether factors related to women, children or participation in services were being measured (Schmied, et al., 2010). On the question of factors that facilitate or hinder continuity and collaboration the review surmised how pre-existing assumptions held about services, issues of trust between services and professions, authority, and time were challenges (Schmied, et al., 2010). Benefits of collaboration included informational continuity, choices for families, trust between professions and agencies, individualised care and improved linkages with families. The authors concluded that while communication occurred in an ad hoc and informal manner between professionals, formal communication pathways would likely improve outcomes for women and their families and particularly the most vulnerable. As such, effective collaboration required knowledge of the roles and responsibilities of professional colleagues and recognition of professional boundaries (Schmied, et al., 2010).

Thompson, Socolar, Brown and Haggerty (2002) studied interagency collaboration through the introduction of a program of intensive home visiting to first-time, low-income mothers across seven counties in North Carolina. One year after the program was implemented more client-level than agency-level collaboration was found (Thompson, et al., 2002). Although it is difficult to ascertain the specific nature of the collaborative efforts referred to in the study, informants identified key aspects that facilitated collaboration including smaller healthcare systems, strong leadership, trust, role delineations, effective communication, having programs under one supervisor and physically close services. Other participants thought funding was most influential and that diverse agency representation and government support, organisational structures, and positive, proactive approaches all played a part in effective collaboration. Although this study involved an equal number of administrators and front-line workers, a limited number of people from each county participated and the extent to which each was considered either a strong or weak contributor was unknown (Thompson, et al., 2002).

A South Australian project evaluating collaborative strategies between hospital and community health services found that the key impediments to collaboration were lack of time to develop trust and set common agendas, lack of resources, professional barriers and existing power structures (van Eyk & Baum, 2002). Participants in this study reported how divided loyalties created a ‘them’ and ‘us’ attitude between hospital and community-based staff and between different professional groups. Working on equal terms and with the same energies was difficult even when a passion to make changes existed because passions were either not equally shared or bureaucratic processes slowed down the process leaving some to ‘go it alone’ while others resisted change (van Eyk & Baum, 2002). The authors concluded that for collaborative activities to be effective aims and vision needed to be negotiated and shared and stakeholders involved early to avoid pre-set agendas and to achieve clarity about what was negotiable and what was not.

Language used to capture how members in healthcare teams work around roles reveals different perspectives on collaboration. For example, one literature review on collaboration noted the use of different and interchangeable terms such as multi-, trans- and inter-professional practice (Heatley & Kruske, 2011). The authors found that professionals might work together with the same client but do so independently, may exchange knowledge, skills and expertise in the process of care, or interact in more complementary ways, that is, to share decision-making. The conclusion was that the best care would come from an inter-professional approach where the team shared decision-making and relied on interpersonal communication rather than formal referral systems (Heatley & Kruske, 2011).

Collaboration has been characterised as shared planning, goal setting, decision-making, interventions and problem solving (Nicholson, et al., 2000; Sullivan, 1998). It is also about how resources such as finances, time, skills or information are used in collaborative efforts and if processes exist formally or informally around this (Meads, et al., 2005). Problem solving is raised as a prime motivator for collaboration since problems or stressful situations can be mitigated by seeking knowledge and support from others (Stefaniak, 1998; Todahl, Linville, Smith, Barnes, & Miller, 2006). This is evident in the work of Todahl and colleagues (2006) where key times were identified when therapists would initiate collaboration with physicians such as where there were dramatic changes in patients, novel ailments developed, or where child abuse or other reportable disclosures were suspected. Other authors have commented on problems as antecedents for collaboration (Lane, 2012b) while adverse events in patient care have also been linked to a lack of collaboration and communication (Fewster-Thuente & Velsor-Friedrich, 2008).

Collaboration is also conceptualised as a continuum that starts with cooperation and moves through coordination and finally collaboration (Sanson, 2006; Socolar, 2002). Walter and Petr (2000) drew a clear distinction between co-existence, cooperation, coordination, collaboration and integration. Frost (2005) conceptualised the continuum as levels from no partnership or uncoordinated services through co-operation, collaboration, coordination and partnership; with a final level where services would partner to become fully integrated. Heatley and Kruske (2011) explored the difference between coordination, cooperation and collaboration in their literature review of collaboration in maternity care. The authors concluded that collaboration was distinguished from coordination and cooperation because it came with an appreciation of the process involved rather than merely acknowledging the benefits of working together for women.

Coordination of care is a term related to collaboration, not described as an intervention or entity in itself, but in relation to care planning. It appears as an attribute of service provision generally understood by health professionals without an explicit definition (Holland & Harris, 2007). Glisson and Hemmelgarn (1998) examined coordination of children's services in America to test if increasing service coordination would directly affect outcomes for children in out-of-home care. Results of this three year study indicated that improvements in the psychosocial functioning of children was significantly greater for those serviced by offices with more positive organisational climates (Glisson & Hemmelgarn, 1998). Furthermore, increased service coordination was found to deflect caseworker behaviour away from other activities associated with quality indicating that coordination was not easily measured. Socolar (2002) alluded to this very dilemma of measuring outcomes when process was the issue.

Integration is a further concept that focuses on creating and maintaining a common structure where independent stakeholders work together on collective projects (Contandrioloulos, Denis, Touati, & Rodriguez, 2003). Boon and colleagues proposed a conceptual framework for integration on a continuum along which patient involvement in and responsibility for healthcare decisions increased towards an ideal of integrative care. On this continuum the authors described collaboration as ad hoc and occurring on a case-by-case basis where practitioners who usually practice independently of each other share information (Boon, Verhoef, O'Hara, & Findlay, 2004). There are few studies, however, that have examined integration or provided examples of integration. Neither of two studies reviewed clearly defined the concept (Hall & van Teijlingen, 2006; Valentine, Fisher, & Thomson, 2006) although other authors focus on how services fit together for common aims or to become one, such as integrating services for young children around child protection (Frost, 2005; Laming, 2003; Siraj-Blatchford & Siraj-Blatchford, 2009). A sense of purpose is commonly agreed as characteristic of how organisations would work together and hence achieve integration. Nonetheless, in one Scottish study participants indicated that while common language and purpose was indeed important for integration the term itself merely represented one further way that language reinvented the idea of working together rather than provide clarity around the issues (Bell, et al., 2008). Case study research conducted in Wales on integration has suggested that, while structural factors are important in integrating care, integration is highly contingent upon interpersonal factors including trust and communication skills (Williams & Sullivan, 2009). Instrumental in interpersonal work were boundary spanners as key actors who promoted communication and trust by seeking consensus and resolving conflicts (Williams & Sullivan, 2009).

Valentine and colleagues (2006) found that facilitating integration involved both management and service level factors of which inclusiveness, relationship building, empowerment and adequate time and resources were important. Policy edicts and time alone did not work without an effort to build and maintain relationships (Valentine, et al., 2006). A Canadian literature review suggested that integration of services for women may be more effective and equitable for specific needs groups (Rodriguez & des Rivieres-Pigeon, 2007). The conclusion was that continuity of care, working in multidisciplinary teams and specific clientele-adapted services were useful mechanisms to make services more effective and accessible for women with specific needs. For other groups of women, however, perinatal services did not need to be tightly integrated (Rodriguez & des Rivieres-Pigeon, 2007).

Collaboration is also used in relation to physical location and organisation of services. Co-location describes the physical sharing of premises by professionals in multidisciplinary teams (Frost, 2005). It has been argued that co-located services can provide better services for children and families through information sharing (Park & Turnbull, 2003; Siraj-Blatchford & Siraj-Blatchford, 2009; Stefaniak, 1998; Todahl, et al., 2006; Wilson & Pirrie, 2000). Yet other commentators caution that even in systems where there is a good amount of contact between services there may be little in the way of collaboration (Darlington, Feeney, & Rixon, 2005). Frost (2005) found that co-location encouraged informal learning, information sharing and enhanced feelings of teamwork and belonging. Further research by Frost and Robinson (2007) on co-location, however, confirmed that something extra is needed to translate co-location into co-participation, a point corroborated in other studies (Barimani & Hylander, 2008). Co-location provided the impetus for integrated work but differences still existed in information sharing and approaches to confidentiality, professional identity and conflicting forms of knowledge (Frost & Robinson, 2007).

In studies of practice, strategies or structures posed that supported collaboration included case reviews, case management, clinical pathways and family meetings. Case management involves a case manager who assesses, plans and facilitates links to services and resources, and advocates for patients (Hesse, Vanderplasschen, Rapp, Broekaert, & Fridell, 2007). Case management for persons with substance use disorders, for example, was examined in a systematic review to elicit its effectiveness in assisting drug abusers to link with other services, reduce substance use and improve quality of life (Hesse, et al., 2007). Hesse and colleagues concluded that, although case management could enhance linkages with services, there was a lack of heterogeneity in the studies about what constituted case management. The case review forum, as examined by Bellamy, Fiddian and Nixon (2006), appeared to assist collaboration by fostering mutual trust and respect among teams and facilitation of skill development such as reflection, role and boundary clarity, teamwork and communication.

Clinical pathways (also called critical paths or care paths) constitute a further tool designed for coordinated and collaborative care in providing a structure to client-focused care. It is also argued that clinical pathways reduce costs and length of hospital stays, embed evidence into practice, increase teamwork and focus on client-centred care (Beckman, Sakulkoo, Hofart, & Cobb, 2002). The family group conference is also a method of collaboration based on a partnership model of decision-making in child protection work (Gallagher & Jasper, 2003). Health visitors have, however, identified limitations in applying the partnership approach in this way because of issues around confidentiality, responsibility and training (Gallagher & Jasper, 2003). Furthermore, while the focus is placed on the relational and process aspects of collaboration and finding solutions with families, there are mixed opinions on how processes like family group conferences improve outcomes in child protection (Sundell & Vinnerljung, 2004).

It is argued that collaboration does not denounce power or influence but rather emphasises shared or collective decision-making power (Kraus, 1984). The idea is that power is grounded in knowledge and experience more so than function or roles (DÁmour, et al., 2005). Stapleton (1998) proposes that power and responsibility in decision-making are shared with the family in collaborative maternity practice because power is based on knowledge and expertise in any given situation rather than on roles or professions. It is also proposed that power is not always clear in collaborative work since informal network influence can be more powerful than formal lines of control and accountability (Meads, et al., 2005). More importantly, the relationship between power and collaboration is perceived as unclear because collaboration can encourage and empower people but can also be used to co-opt and control (Meads, et al., 2005). Meads and colleagues made the point that collaboration does not mean removal of differences but is a strategy and a forum for managing differences. Other authors make reference to how power operates over, with and for others and suggest that in most collaborative endeavours each of the three power types exist to varying degrees (Keast & Mandell, 2011b).

A prevailing issue around collaboration is the time consuming aspect of this work because building relationships and trust are part of the process (Bailey, Jones, & Way, 2006; Fewster-Thuente & Velsor-Friedrich, 2008; Johnson, et al., 2003; Moore, 2007; van Eyk & Baum, 2002). One study addressing collaboration over time found that after one year of implementation of a collaborative project, cooperation and coordination were evident but no merged and integrated programs had resulted (Thompson, et al., 2002). The biggest barriers to collaboration identified by participants were lack of time, turf issues, scarce funding resources, information sharing and issues of confidentiality (Thompson, et al., 2002). Other studies have revealed similar barriers including professional silos, hierarchies of credibility, poor communication, conflicting ideologies, and models of care (Fridgant, Davies, O'Toole, Betbeder-Matibet, & Harris, 1998; Murray-Davis, et al., 2011).

Collaborations are also recognised as developmental because time and hard work are needed for them to develop (Johnson, et al., 2003; Stapleton, 1998). Johnson and colleagues (2003) identified seven factors important to interagency collaborations such as strong leadership, serious preplanning, adequate resources, minimising turf issues, understanding the culture of the other, commitment and communication. Johnson and colleagues made the point that by using a cultural view, different agencies would seek solutions that were sensitive to the professional and organisational cultures of others and therefore it would be less likely that differences in rules, values, communication patterns and other structures would be perceived as wrong.

The following section will build on the above outline of the assumptions that underpin the concept of collaboration in focusing more closely on the care continuum in maternity and child health care which is the context for this research. The care continuum, discharge process and care partnerships are described in the literature around this context.

2.4 THE CONCEPT OF COLLABORATION IN THE CARE CONTINUUM

2.4.1 The Continuum of Care

McBryde-Foster and Allen (2005) conducted a search of nursing and allied health databases to explore the meaning of continuum of care. The continuum was understood as a series of care events occurring when patients sought providers in one or more environments in the healthcare system and where the patient remains the central focus as transition between settings occurs (McBryde-Foster & Allen, 2005). Gaps or duplication of care, improved or disconnected relationships and full or limited communication all directly affected outcomes of care (McBryde-Foster & Allen, 2005).

Evidence that the transition is not seen as patient-focused was illustrated in a study of postnatal services in Canada. The authors contacted 1158 women in a large urban area in Quebec one month after birth to ascertain the services they had received from the hospital. The findings were compared with service guidelines for postnatal care. It was revealed that 56% of hospitals continued to be involved with women for postnatal follow up even though Ministry directives did not support this practice (DÁmour, Goulet, Labadie, Bernier, & Pineault, 2003). By contrast, only a limited number of the women were telephoned or visited within the recommended timeframes after discharge. The overall result was duplicated services for 45% of newborns. DÁmour and colleagues (2003) interpreted their findings from a number of perspectives. From a cultural perspective the conclusion was that hospital professionals had limited understanding of the competencies of community nurses and the nature of their work leading to reluctance to transfer care. From a strategic perspective the lack of guidelines for perinatal services meant that individual services developed their own systems as ‘safety nets’ for postnatal care. From a structural perspective the large size of this healthcare network meant that few women in a particular community district gave birth in an associated hospital making it difficult for systems to be integrated. Finally, from a technological perspective there were information transfer deficiencies between organisations leading to long delays in community health centres being advised of births (DÁmour, et al., 2003).

Homer, Henry, Schmied, Kemp, Leap and Briggs (2009) examined the transition of care between midwives and child and family health nurses in Australia in a similar way. Midwifery and child health managers and clinical leaders in this study identified a number of transition models that varied from the quite informal to the very structured. Systems were found to be predominantly structured around non-verbal communication of information between services via fax or computerised system. Other models involved liaison or discharge roles, while purposeful contact between staff was less common and mainly used for identifying at-risk women. The authors concluded that many of the transition models were developed as ‘bandaid’ measures that were not coordinated and relied on the goodwill of individual clinicians to make things work (Homer, Henry, et al., 2009). While acknowledging that flexibility in local models was important, more coordinated and systematic approaches were considered important to meet the needs of women. The opinion of women was not included in this study and although it was noted that policies supported the notion of women, children and families as the centre of care, there was limited evidence of this in practice (Homer, Henry, et al., 2009).

A more recent Queensland study explored the transition of women from maternity services to community child health services using a longitudinal, mixed method design (Rowe, Barnes, & Sutherns, 2013). The study explored the experiences of women attending the Newborn and Family Drop-in Service (NAFDIS), a service provided collaboratively in the community by midwives and CHNs for women with infants between birth and eight weeks of age. Data indicated that 92.5% of women attended the service following referral by their maternity service provider with more than half attending within a week of the baby's birth, and 30% within two weeks (Rowe, et al., 2013). Women attended the service because of accessibility, for breastfeeding support and to have a blood test. There were no data to indicate where women attended for ongoing child health care.

2.4.2 Discharge Planning and Transitional Care

Although there is abundant literature on discharge planning very few studies explicitly define the concept despite its existence for over 60 years (Holland & Harris, 2007). The term transitional care emerged more recently, perhaps in the 1980s. Terms such as continuity of care and coordination of care are often used interchangeably with discharge planning and transitional care (Holland & Harris, 2007). The focus of discharge planning is an end point when a patient has left the care of a particular service, or is bounded by admission or discharge to specific care settings (Holland & Harris, 2007), while transitional care implies movement across settings and boundaries.

The American Academy of Pediatrics (2008) identifies six critical components of planning for ongoing care at discharge including educating parents, completing primary care needs, development of management and home-care plans, identification and involvement of support services, and determination and allocation of follow-up care. Hospital nurses, however, may not readily see the significance of discharge planning because they know little of the outcomes of such plans (Hofmeyer & Clare, 1999). Information priorities also differ where, for example, social history is a low priority for hospital staff, possibly because this type of information is perceived as relatively unscientific (Atwal, 2002).

A qualitative study of Swedish midwives and CHNs assisting new parents on follow-up care after hospital discharge found that linkage was virtually non-existent as a 'chain of care' despite a desire for this to occur (Barimani & Hylander, 2008). Rather, midwives and CHNs focused on their own 'link' by taking into account their own facility priorities which meant that actions were not conceived of as part of a continuum. Contributing factors to this were inadequate information transfer, physical distance between services, time and task territoriality and different perceptions of professional or parental gain (Barimani & Hylander, 2008). The participants drew attention to how cooperative relationships subsequently collapsed because so much energy was required to sustain this work. The view of CHNs and midwives was that an overriding management function for the whole process would progress collaboration (Barimani & Hylander, 2008).

Key people, referred to as bridges, brokers and boundary spanners in collaborative healthcare networks, are thought to improve knowledge transfer and liaison between settings, although a systematic review concluded this was not the most efficient way to transfer information (Long, Cunningham, & Braithwaite, 2013). Discharge liaison nurse, liaison nurse or discharge coordinator are common terms used to describe roles that facilitate transition of care between healthcare settings (Armitage & Kavanagh, 1996; Bajaj, Mease, Allen, & Dryburgh, 2006; van Emden, Wynnand, & Berns, 1999). While most roles are concerned with facilitating information transfer some provide direct care across the continuum (Rose, Gerson, & Carbo, 2007). Information exchange is a recurrent theme in the literature around the discharge role. A number of studies highlight the importance of the roles when more complex situations occur such as where there are child protection concerns or families are linked with numerous agencies (Bajaj, et al., 2006; Katz, Ceballos, Scott, & Wurum, 2007). On the other hand, critics suggest there is limited evidence that the roles improve either follow up community care or information exchange (Houghton, Bowling, Clarke, Hopkins, & Jones, 1996; van Emden, et al., 1999).

In the Netherlands, it has been reported that 48% of hospitals have a discharge professional, most often a nurse from a community agency based in the hospital (van Emden, et al., 1999). The most common reasons cited for introduction of the role were to address problems occurring in discharge of patients to community care (van Emden, et al., 1999) and to correct failures in the documentation and follow-up of child welfare concerns (Bajaj, et al., 2006). Bajaj and colleagues (2006) found that despite some success in raising awareness and improving documentation in hospitals, outcomes were available for only 33% of children referred to social services despite coordinators having regular liaison meetings with them. In addition, discussions with other professionals such as health visitors and school nurses tended to be informal because formal feedback systems did not exist (Bajaj, et al., 2006).

A study conducted in the Republic of Ireland found similar issues whereby discharge coordinators worked mostly with complex cases and multidisciplinary teams with communication forming a large part of their work (Day, McCarthy, & Coffey, 2009). Direct engagement with social workers or community welfare officers during discharge planning processes was not common despite many cases being complex (Day, et al., 2009). Methods of information transfer included occasional letters, phone calls and facsimiles, occasional meetings, multidisciplinary team case conferences and home visits although the majority of the coordinators did not use standardised assessments to collect information. Many coordinators felt isolated in their work and none had formal training in community nursing but rather acquired knowledge of services through practice and by developing good working relationships with community nurses (Day, et al., 2009).

An earlier exploratory study conducted in Northern Ireland on discharge planning across hospital and community services concluded that while hospital nurses found communication very good, their community counterparts disagreed (McKenna, Kenney, Glenn, & Gordon, 2000). The key area identified for improvement was correct documentation, although more timely notice of discharge was also important. The perception of nurses was that the different sectors lacked awareness of the information required and that this demonstrated a lack of understanding of staff roles and multidisciplinary work (McKenna, et al., 2000). The authors concluded that little had changed over more than 20 years so the key issues to remedy the situation were to standardise processes and come together as one team.

Armitage and Kavanagh (1996) focused on the role of the discharge liaison nurse as a link between hospital and community services. This qualitative Australian study found that a range of viewpoints and priorities meant that no total picture of patient care needs existed. While hospital nurses relied on the liaison nurse for consultation and advice on planning for patient needs and to liaise with community services, community nurses relied on the nurse as a link with hospital services to provide appropriate and timely information and to coordinate services. Written referrals transmitted to the community centre were often supported by direct telephone communication with community nurses in an effort to build rapport and to save time (Armitage & Kavanagh, 1996). The authors also noted that when the liaison role was introduced, ward nurses tended to hand over their discharge responsibility which meant that the nurse who knew most about a hospital patient was no longer the one providing information directly to the community nurse (Armitage & Kavanagh, 1996).

Other studies comparing hospital and public health liaison nurses in postpartum settings have also found that hospital nurses may be better equipped than liaison nurses to identify women requiring home visiting (Ciliska, et al., 1996). Ciliska and colleagues (1996) found that hospital nurses correctly identified 62% of mothers requiring home visiting while the liaison nurse correctly identified 47%. The study, however, was conducted over a relatively short period of time and did not assess if the skills learned by hospital nurses were retained.

A more recent study in Queensland by Jenkinson, Young and Kruske (2013) focused on management of the discharge process by maternity services. The aim was to find ways to minimise fragmentation in the care of women and families transitioning between hospital-based postnatal care and community-based care. Gaps identified included a lack of involvement of women in the development and dissemination of discharge summaries and time delays in information transfer to community care providers. For example, three fifths of birthing hospitals involved in the study did not have a process for women to check the accuracy of discharge summaries prior to distribution. Gaps also existed in transfer of certain types of information, for example, psychosocial and cultural aspects of care, information about the baby and care provided by domiciliary staff (Jenkinson, et al., 2013).

2.4.3 The Care Partnership

Work on collaboration in healthcare makes reference to the roles and relationships between patients, clients and consumers in care. The language of partnerships emerged in the UK at a time when private and public sectors were brought together to finance large scale projects (Bury & Taylor, 2008). Furthermore, as part of health reform, partnership shifted focus to the patient, replacing consumerism as a key part of health policy in the UK (Calnan & Gabe, 2001). The concept of partnership entered child and family healthcare with the work of Davis and colleagues who argued that professional roles be based not on an ‘expert’ model but a ‘parent adviser’ model (Davis, Day, & Bidmead, 2002). The concept has become clinically embedded within care relationships reflective of the changing nature of health and social relations in healthcare. For example, chronic and extended care situations now necessitate longer term relationships and shared decision-making between health professionals and patients where the focus is on care not cure; hence partnerships are assumed (Bury & Taylor, 2008). Further, the shift to individualised care, at the patient level, saw the term partnership linked with patient/family-centred care. The implication is that quality care and positive outcomes for patients, organisations and healthcare professionals can be mutually achieved through shared decision-making and shared power (Lusk & Fater, 2013).

Wiggins (2008) described the partnership care delivery model as primarily a partnership between patients and families with nurses, although doctors were also involved. The role of nurses was to work collaboratively with healthcare experts to coordinate care. Attributes suggestive of partnership included shared knowledge, power, responsibility, decision-making and information that was supported by communication, trust, respect and reciprocity (Wiggins, 2008). The consequences of partnership included achieving mutual goals whereby patients gain a sense of control, self-esteem, competence and confidence; and where health professionals gain through job satisfaction, role clarity and reduced stress.

Difficulties in realising the concept of family-centred care in terms of parental roles, participation, negotiation and decision-making have been identified (Corlett & Twycross, 2006; Coyne, et al., 2011; Shields, 2010). Corlett and Twycross (2006) argued that relationships often developed informally rather than as a result of any deliberate negotiation process. Ineffective communication, unclear and divergent expectations, issues of power and control as well as inadequate resources and lack of management support inhibit negotiations between families and nurses (Corlett & Twycross, 2006; Coyne, et al., 2011). Furthermore, Blower and Morgan (2000) found that while the vast majority of nurses reported discussions of shared roles with parents only two-thirds of parents in their study agreed that this had occurred.

In the neonatal intensive care and paediatric inpatient settings nurses question whether parents could be equal partners in care (Coyne & Cowley, 2007; Trajkovski, Schmied, Vickers, & Jackson, 2012). Coyne and Cowley (2007) studied the philosophy of partnership in the acute paediatric setting in England. This study challenged the notion of shared responsibility as mutually satisfying. Rather, parents reported feeling a major responsibility for care and that staff avoided or abdicated responsibility in a laissez-faire approach (Coyne & Cowley, 2007). On the other hand, nurses in the study reported feeling pressured to comply with the ideology of partnership with parents which was not reflective of actual practice (Coyne & Cowley, 2007).

Trajkovski and colleagues (2012) explored the partnership approach in a study of family-centred care in an Australian neonatal intensive care unit (NICU). The findings indicated that the partnership process was fluid and constantly changing and that negotiation of roles and responsibilities was about achieving a happy medium. Tension was revealed between nurses wanting and expecting parents to be involved in the care of their babies while at the same time wanting to retain some control over parents (Trajkovski, et al., 2012). Nurses drew attention to the time demands of the partnership approach and while being in conversation with parents and hearing their stories was useful, individual nurse/parent factors influenced how this process occurred. Similar findings about the oscillation between exclusion and participation were found in a Swedish study in a NICU setting (Wigert, Johansson, Berg, & Hellstrom, 2006).

The ad hoc character around partnership and collaboration in care was also raised in a study by Lee (2007) of children's nurses. Nurses in this study identified that effective partnership in care was possible if positive attitudes, respect, good communication and parental understanding were present. Further, improved well-being was not only about child and family outcomes but how the multidisciplinary team derived satisfaction from the partnership approach. It was suggested that partnership took a variety of forms and that it should be rendered more quantifiable and less ad hoc (Lee, 2007).

The family partnership model referred to previously is described as a tiered system of care that builds on basic skills of child and family workers in communicating with parents wherein different levels of need require coordination and collaboration with other multidisciplinary team members (Davis, et al., 2002). Evaluation of the model in Australia has indicated that while health professionals report gains from initial training, changing practice to a facilitative role was time consuming and challenging, both personally and professionally (Keatinge, Fowler, & Briggs, 2007-08). Other studies allude to the need for extra time to practice partnerships and so funding and organisational support to formally sustain the practice is vital (Coyne, et al., 2011; Hopwood, Flowler, Lee, Rossiter, & Bigsby, 2013; Purcal, Muir, Putulny, Thomson, & Flaxman, 2011). Organisational and political factors place constraints on partnership practice where, for example, policies talk of continuity of nurse/family relationships but are not reflective of how services are structured (Hopwood, et al., 2013).

There are different representations of partnership suggesting it refers to a practice approach and also relationships. For example, Freeman (2006) linked the concept of partnership and continuity of carer in her review of literature on midwifery care and found that woman referred to the caseload model of midwifery practice in terms of personal friendships with midwives. Midwives referred to partnerships as relationships formed with women and improved interdisciplinary relationships which were a source of satisfaction (Stevens & McCourt, 2002). Others have debated the use of the term partnership with women in maternity care as opposed to the word collaboration (Kruske & Heatley, 2010).

An underlying principle thought to indicate partnership is the redistribution of professional power so that people share authority, although studies have indicated this is difficult to sustain and is constrained by organisational and individual factors (Coyne & Cowley, 2007; Coyne, et al., 2011; Fowler, et al., 2012; Kruske, Barclay, & Schmied, 2006; Trajkovski, et al., 2012). Patients can be thrust into responsibility and participation in healthcare using patient collaboration to portray individualised care without clear indication of how those patients will be involved in their care (Shields, 2010; Waterworth & Luker, 1990).

This chapter concludes with some final comments on the concept of collaboration outlined in the contextual review of literature.

2.5 THE CONCEPT OF COLLABORATION

The contextual review of the literature above demonstrates that the concept of collaboration is complex. There are a number of ways the concept has been defined and operationalised. The term is often coupled with other concepts including inter-professional collaboration, professional cooperation, interagency collaboration, collaborative practice, integration, continuity and various care partnerships. Lack of clear definitions and conceptual frameworks, an absence of attention to temporal factors in the processes of collaboration, use of terms interchangeably without clarity, and varying perspectives on how to measure collaboration limited the findings of a number of studies.

The notion of collaboration raised in this review reveals how the concept is frequently identified by deviant or contrary case analysis, that is, the identification of collaboration by what it is not rather than what it is (Freshwater, Cahill, & Essen, 2013; Henneman, et al., 1995; Lusk & Fater, 2013). The historical background demonstrates how this concept has continued to elude understanding while many of the concerns around which collaboration has been associated continue to endure in healthcare. Enduring assumptions suggest the limitations of structural and functional analytical frameworks for understanding the concept. Opinions are that common management, formal agreements and structured systems are needed to ensure people and services work together, while an alternate view is that people need to work out for themselves how collaboration will unfold and take a certain form in particular contexts. Commonly held views concern how the concept is a developmental process requiring a lot of time and hard work, careful planning and contingencies. The assumption is that it may never be fully realised and, if it is, that it can break down at any stage without ongoing work. The alternative view is that ad hoc and everyday work best describes the concept of collaboration so it is occurring all the time in different ways.

Common attributes of and antecedents for collaboration have been stated as clear and shared goals, shared decision-making, equal power sharing, shared responsibility, adequate time, trust and respect in relationships and adequate funding. This notion of collaboration as something shared heightens the differences that exist furthering the view that strong leadership and commitment will bring all together and make it work. Many studies draw attention to information and communication as key issues for collaboration which perpetuates assumptions about how interactional or structural approaches best function to facilitate collaboration. There are conflicting positions on structural systems approaches and individual approaches and what is specifically involved. Less work has considered the concept of collaboration within a social framework that does not present systems and individuals as dichotomous variables.

A further assumption drawn from the literature is that conflicting and coexisting ideas about professional and consumer gains around collaboration exist while the experience of healthcare users appears limited in this analysis. Divergent opinions about clarity of roles and responsibilities, role blurring and system issues, sustain the focus on collaboration as a professionally driven issue which does not look at the wider socio-political context. Many studies have also anchored reviews of collaboration within healthcare organisations at specific points in time that have provided useful insights into some characteristics of collaboration, although there have been limited attempts to understand the processes and the function of collaboration on a broader level. A further position drawn from the literature is that much empirical work on the concept of collaboration has drawn upon existing sources of knowledge developed through frameworks that inadvertently carry hidden assumptions into the studies, replicating existing viewpoints if in slightly different ways. This is because much empirical work has focused on concept analysis and literature reviews on collaboration.

A review of literature in qualitative inquiry seeks to set the scene and focus for research, orientate the reader to the research context and provide some broad ideas for engaging with the data during analysis. This contextual review is not exhaustive, primarily because the function of the review was to establish a position on collaboration by exploring potential underlying assumptions. What is clear is that the concept of collaboration lacks clarity in healthcare. This gives support to an open approach and a broad sociological framework in generating fresh analytical ideas around the concept. Exploration of the concept of collaboration that takes into account a specific healthcare context such as the care continuum will provide insights into the process and function of collaboration that may be useful in other contexts. Linking this work to the policy context will consider broader social influences.

The following chapter will outline the philosophical and theoretical foundations that underpinned the interpretive social framework and progressed ideas around the concept of collaboration. The chapter traces the development of the constructionist philosophical position to be adopted, elaborates the theoretical foundations that underpinned the research and outlines how a social framework facilitated a critical analysis of the concept.

Chapter 3: Situating the Research

3.1 INTRODUCTION

The purpose of this third chapter is to make explicit the philosophical and theoretical foundations underpinning the interpretive research frame. Three key theoretical dimensions will be outlined in detail in this chapter. First, a grounding philosophical position is developed and its connections with the research questions posed in Chapter One explained. Second, theoretical views aligned with this philosophical position and relevant to the research are argued. The chapter elaborates key concepts and ideas used to generate a theoretical understanding of the object of inquiry. These essential points pave the way for Chapter Four and an exploration of the research methods.

3.2 ESTABLISHING A PHILOSOPHICAL POSITION

The central focus of this research was to capture a theoretical understanding of the concept of collaboration as it existed in a healthcare setting. The aim was to access the day-to-day thoughts and actions of CHNs, midwives and women, to analyse and interpret these and to inform more deeply current understandings around the concept of collaboration. The research focused on the processes by which knowledge was developed, transmitted and maintained in the social context because this was a critical means to understand human phenomena. This process embraces interaction and elevates interpretation to gain understanding. The discussion begins with an elaboration of the position of constructionism. This is followed by an explanation of the theoretical foundations of social inquiry aligned with this position before introducing key theoretical concepts and ideas that underpinned the inquiry.

3.2.1 The Philosophical Position of Constructionism

People are first and foremost social beings unable to be understood in isolation from their social worlds. Charles Cooley stated this succinctly in referring to individual and society as not separable but as "collective and distributive aspects of the same thing" (1983, pp. 36-37). This means that in understanding aspects of human experience, such as the object of this inquiry, the individual and the social world must be approached in a way that conceives of them as conterminous. The position of constructionism looks upon the world in this way because knowledge is not seen as either an objective truth or a subjective experience but rather as something that people “do together” (Burr, 2003, p. 9). Essentially the edict of constructionism is that “...all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, p. 42). This philosophical position purposefully avoids intellectualising the individual/social dichotomy and instead shifts the focus to understanding the social *processes* occurring as people interpret and define their worlds. Constructionism provides a path to this understanding because focusing on processes is the key to drawing subjective and objective realities together.

The research embraced the processes of interpretation and definition as pivotal in constructing the meaning of collaboration. These two intrinsically social processes describe how people call upon various experiences to make sense of and construct their worlds. This becomes the basis for action and through this action the world is also shaped. Interpretation is critical here for no matter how the social world is approached meanings are never self-evident; the process requires work (Hunter & Ainlay, 1986; Steedman, 1991). Meaning in a situation cannot be discovered as if it existed by and of itself. Rather meaning is constructed as people engage with, define and actively interpret their worlds and thereby leave their marks on those worlds as an ongoing process.

The central concern in the research was to engage with CHNs, midwives and women going about everyday activities in the care continuum process to explore the associated interpretive and definitional processes. The aim was not to prove the validity or otherwise of knowledge and meaning but to explore the *processes* by which knowledge and meaning was constructed. This approach recognises knowledge as socially relative because different people construct realities in different ways and in various contexts even in relation to the same phenomena (Berger & Luckmann, 1966; Crotty, 1998). The versions of events people construct are therefore subjectively and socially negotiated realities. The central point here is that the position of constructionism focuses on understanding the processes involved in meaning construction, how people interpret, define and construct situations to arrive at meaning, how this shapes actions and how this in turn shapes their world. This position is vital in understanding the object of inquiry because this recognises that interaction and context are significant to meaning, not one more than the other. Before turning to the key concepts and ideas that directly informed the inquiry, a review of the research context raises further analytical points.

3.2.2 The Research Situation

The aim of the research was to gain an understanding of the concept of collaboration as it existed in the care continuum between maternity and community healthcare settings. The focus was the experiences of women, midwives and CHNs in this complex context. It was argued in Chapter Two that collaboration, as a concept, lacks clarity despite being studied from a range of theoretical positions. The concept therefore continues to be broadly applied and widely used without clear meaning. The concept implies individuals working together while empirical accounts and related commentaries indicate that collaboration is interpreted and operationalised in various ways.

Ambiguity around human phenomena, such as collaboration, is sustained where it is explored outside a sociological perspective. This is because broader socio-cultural influences, that is, cultural, professional, organisational and political factors are largely obscured. Hence, the objective here was to explore the concept of collaboration in a different way to advance current thinking. As Pascale (2010) argues, the social sciences are changing continuously and thus the need for ongoing questioning of the theoretical foundations of inquiry and the limits placed on what is known. A sociological perspective was important because the social context was integral to the construction of collaboration.

The care continuum itself is not a location or a point in time; rather it is a complex and unbounded period of care where women, midwives and CHNs come together. Part of this complexity includes conflicting agendas that determine interaction around pregnancy, birth and parenting such as competing professional and personal advocacies on the wellbeing and safe care of children, supporting women actively in their maternity care and supporting families in their parenting role. Further, there are varying opinions on the part individuals, professions, institutions and political interests should play in this situation. This is reflected in contemporary discourses around family partnerships, family-centred, woman-centred and child-focused care. In addition, changing boundaries between healthcare providers and between professionals and healthcare consumers, along with other social and workforce reforms have seen the reconstruction of responsibilities and relationships in health systems (Boreham, 2002; Lane, 2006; Nancarrow & Borthwick, 2005). Furthermore, current representations of pregnancy, birth and parenting acknowledge that health and wellbeing rely on biophysical, psychosocial and environmental factors that bring a range of understandings and interpretations of health risks and morbidities to a situation. Influences such as these necessitate an inclusive, social framework in interpreting concepts such as collaboration.

The argument put forward in this thesis is that many things are likely to influence the reality of collaboration and therefore a framework that brings together individual and social meanings of the situation is needed. A sociological perspective provides a rich field of theoretical concepts and ideas for an inclusive and flexible interpretive frame. Charmaz (2006) points out that concerns from within the sociological field open up different possibilities for theorising, for example, around issues of power and prestige, choices and constraints, and standpoints and differences. The following turns to some of the key theoretical foundations adopted in the research and the interpretive resources applied to stimulate critical thinking on the concept of collaboration.

3.3 THEORETICAL FOUNDATIONS: THE SOCIOLOGICAL POSITION

Every theoretical perspective focuses on some dimensions of society, people and behaviour that are worthy of attention (Stryker & Serpe, 1982). One cannot assume that a single, unified theoretical framework is available that would sufficiently and comprehensively incorporate all that is important to work with a situation (Stryker & Serpe, 1982). This is the position taken in this research. The idea was to start with some general conceptual ideas whereby the research situation could be interpreted. This meant developing some starting ideas that could be reflexively refined to understand the situation in a way that recognises interaction and context as interdependent and equal ways of viewing knowledge and meaning.

This iterative process avoids merely ‘applying’ theory instrumentally to what is studied because this is not the way the social world exists. Instead the process involves thinking with theory (Jackson & Mazzei, 2013). This is because concepts are developed in the course of seeking answers to research concerns as those concerns can be posed in various ways and phenomena conceptualised differently along the way (Stryker & Serpe, 1982). The following makes more explicit the building blocks that theoretically underpinned the research.

3.3.1 Sociological Foundations of the Construction of Knowledge and Meaning

The origins of understanding on knowledge and meaning in the social world has no one identifiable source although early thinking about knowledge and meaning was evident in the writings of Husserl, Heidegger, Bergson and Schutz (Wagner, 1970). Over time, various scholars have drawn on these views and shaped them in slightly different ways. The essential grounding philosophy was that nothing could be adequately described without considering it in terms of human experience. Husserl (1954/1970) called into question, not an objective world as it actually is, but a subjective one valid for and conscious to persons as it appeared to them. Heidegger developed this thinking in moving on from the individual experience to consider the social context. For Heidegger, the development of understanding was in interpretation that came from involvement and participation in the world and was contingent upon people relating to others through relationships, language and behaviours (Heidegger, 1953/1996; Parsons, 2010). The ongoing development, sometimes referred to as the sociology of knowledge, appears in the works of Max Scheler, Karl Mannheim, Alfred Schutz, Peter Berger and Thomas Luckmann. The following looks at the genesis of the notion of knowledge as socially constructed; how it is essentially shared and as such is not free of the social world in which it exists.

Alfred Schutz (in Wagner, 1970) emphasised how subjective meaning is the result of a person's membership of their community; in other words individuals construct their worlds with the help of building blocks offered to them by others. Schutz drew upon William Thomas' (1923) concept of the definition of the situation to describe ways in which people orientate themselves to their worlds by working with culturally pre-established definitions of typical situations and deliberating upon them to attribute meanings to new and atypical situations (in Wagner, 1970). For Schutz the 'life world' was a social world somewhat pre-structured for the individual but also constructed subjectively as individuals interpreted their worlds and defined their own places therein (in Wagner, 1970). Schutz's point was that even the most stereotyped cultural ideas only exist in the minds of individuals who absorb them and interpret them on the basis of their own life situation.

For Schutz, inquiry starts with the knowledge of everyday life and considers how this stock of knowledge is structured through, for example, "systems of relevances" (in Wagner, 1970, p. 321). Some relevance systems are social and thus imposed on people while some are dependent on context. Other relevance systems are volitional; that is individually defined. The point was that individuals ascribe relevance to selected aspects of the world to make that world cognitively manageable according to the specific interests at hand. To do this, Schutz, (in Wagner, 1970, pp. 23,112), suggested that knowledge existed as "zones of relevance" because some things needed to be clearly understood to master day to day situations while others may be less relevant or irrelevant to what is at hand.

It was left to Berger and Luckmann (1966) to explain more specifically a sociology of knowledge by elaborating the subjective and objective meanings that Schutz had earlier outlined. They specifically referred to "the dual character of society in terms of objective facticity and subjective meaning" (Berger & Luckmann, 1966, p. 30). So, while Schutz had described subjective meaning as that which a person ascribed to their own experiences and actions, Berger and Luckmann argued that knowledge was learned as objective truth through socialisation and then internalised subjectively as reality. This latter perspective saw a theoretical shift towards a focus on the actual processes involved as individuals construct meaning and thus appeared as a bridge between social and psychological domains of knowledge (Berger & Luckmann, 1966). This perspective recognises that there is always a subjective dimension to everything social and hence is applicable in generating an understanding of a concept that is neither discretely individual nor social. Further, and in drawing attention to how knowledge is socially distributed as an important element (Berger & Luckmann, 1966), this perspective allows an exploration of how knowledge is used to position people in situations. These are situations where interaction and context are significant, not one more than the other.

A number of interrelated but slightly differing perspectives on human interaction in terms of knowledge and meaning evolved within the tradition noted above. These viewpoints also provided interpretive resources for the research. One such perspective, symbolic interactionism, focuses on how interaction contributes to the construction of realities which was important to the understanding of collaboration.

3.3.2 Symbolic Interactionist Foundations of the Construction of Knowledge and Meaning

Herbert Blumer, an American sociologist, first coined the term symbolic interactionism although it was his teacher, philosopher and social psychologist George Herbert Mead, who provided the conceptual foundations (Blumer, 1969; Mead, 1934). Their combined works provided a way of viewing human interaction and conduct that centred on three important premises. The first was that human beings act toward things on the basis of the meaning that these things have for them; second, that meaning arises in the process of interaction between people and third, that these meanings are handled in and modified through an interactive process (Blumer, 1969). The framework recognises that group life has a decisive influence on experience (Blumer, 1969).

Mead pointed out that human beings have selves and so do not merely respond to the world but rather people consciously construct actions through the process of interpretation and definition (Blumer, 1966). For Mead, self was a process because human beings perceive, have conceptions of, communicate with and act toward the self and become objects of their own action (Blumer, 1966). In forming this position, Mead and Blumer also drew upon Thomas' (1923) concept of the definition of the situation to argue that instead of reacting instinctively to other's actions (non-symbolic interaction), human beings actively deliberate upon situations and through *interpretation* and *definition* construct their actions and responses (Blumer, 1966, 1969). This is how symbolic interaction works since meaning arises where the gestures of one person in an interaction brings about the indicated response in another to which it is directed; essentially the meaning lies in the response (Mead, 1934).

Symbolic interactionist views of human interaction focus on how human action and meaning is conceived as *built up* because the process of interpretation and definition of each other's actions is ongoing (Blumer, 1966). This perspective is useful in exploring situations that involve ongoing reproduction of the human act that is not reactive but highly contingent and reflexive of changing relations as occurs within healthcare contexts. Environments such as healthcare are acutely vulnerable to social and political influences. Fundamentally, symbolic interactionism shifts the focus from being preoccupied with what initiates or results from actions to the *process* involved in human action in much the same way that Berger and Luckmann proposed. Blumer suggested that having common values was not a necessity for symbolic interaction; his point was that society could be conceived in terms of "workable relations" (1966, p. 544). This approach opens up a lens for understanding a range of human associations such as cooperation, conflict, domination, exploitation, consensus, disagreement and indifference (Blumer, 1966) all of which are integral to the research context.

The concepts inherent to symbolic interaction such as definition, interpretation and workable relations were important dimensions of human interaction that offered a lens through which to interpret how and why participants from different world views came together in this research. Other sociological works, including related concepts from the work of Goffman, provided further tools for interpretive work.

3.3.3 Related Perspectives on the Construction of Knowledge and Meaning

Erving Goffman, a Canadian sociologist and writer, while working somewhat within a symbolic interactionist perspective, broke with some interactionist principles by elaborating other ways that people make sense of their worlds. Drawing together Thomas' concept of the definition of the situation and Bateson's term frame, Goffman conceived of "frame analysis" as a way of examining the foundation upon which people interpret, build up and understand what is going on in situations; how experiences are organised and how these guide actions (1974, pp. 11, 13). Goffman (1974) saw that people attributed meaning to otherwise meaningless events and situations by locating, perceiving, identifying and labelling them using frames in a way somewhat similar to Schutz's relevances.

This perspective gave rise to the idea of an "interaction order" or a social framework of understanding where conventions and ground rules inform interaction (Goffman, 1983, p. 6). It is proposed that people go along with rules and conventions for various reasons, for example, as a consequence of their place in the social structure, differential rights or when weighing up the cost of dissention (Goffman, 1983). Goffman argued that individuals manage their own and others' impressions of each other by continually gleaning clues from the conduct, appearance and experience of others to know what to expect of each other (Goffman, 1967). Rules and conventions in interactions therefore create social sub-systems that constitute a degree of social order (Goffman, 1974). By honouring rules and conventions and concealing potentially rival definitions, situations can be handled within a framework acceptable to all present in the situation (Goffman, 1967). Goffman summed up how the “veneer of consensus” worked:

> Together the participants contribute to a single over-all definition of the situation which involves not so much a real agreement as to what exists but rather a real agreement as to whose claims concerning what issues will be temporarily honored. (1967, p. 226)

Goffman made the point that definitions may be already built into situations in different ways. As did Berger and Luckmann (1966) and Schutz, (in Wagner, 1970), Goffman (1974) explained how processes like this could predefine conduct thereby constraining, enabling and shaping interactions while also recognising that people have the ability to rework, transform and alter definitions to manage social and subjective realities. This way of looking at human interaction was important to this research since processes provide a view on relations within complex systems such as healthcare where co-existence of competing ideologies occur and where human interaction and context are equally significant. Exploring how interaction occurs through consensus and impression management provided an understanding of how situations could be reasonably negotiated around potential constraints.

An additional theoretical conceptualisation that sits logically with and expands upon the ideas above and that informed the research analysis was the process of identity. Identity processes focus on how people are shaped by and positioned within the world and what it is in particular situations that influence this negotiated process. This is an important extension of the above concepts in capturing how identity processes were relevant to this inquiry.

3.3.4 Identity Processes and the Construction of Knowledge and Meaning

Perspectives on identity provide important insights into the processes by which subjective and social worlds are brought together. This is because the process of identity indicates how individual and social identities are shaped, maintained and modified by social relations and how this process contributes to knowledge and meaning in situations. We study identity because it tells us how the broader social situation interacts with the individual and therefore how issues of human interaction such as collaboration are shaped and maintained. The social dimension of identity was first mooted when William James (1890) suggested that actors have as many social selves as there are individuals (or groups) who recognise them. In this process people reveal different sides of themselves to different others making a particular self actual by temporarily suppressing other possible selves in a situation (James, 1890). Berger and Luckmann posed similar views when referring to the “repertoire of identities” that society holds and are known to its members (Berger, 1966, p. 11; Berger & Luckmann, 1966).

Identity theories often draw attention to the “parallel but separate universes” of self identity and social identity (Hogg, Terry, & White, 1995, p. 255). Self identity refers to the meanings tied to and sustaining people as individuals while social identity refers to people belonging to particular groups or having certain roles (Stets & Burke, 2000; Stets & Cast, 2007; Stryker & Burke, 2000; Tajfel, 1978). The two are not separable because the personal self is formed, maintained and modified by social relations as meanings are internalised from social experiences (Berger & Luckmann, 1966). Internalised meanings are reflected back upon the social situation functioning to verify individuals in certain ways (Berger & Luckmann, 1966).

Identity is significant to this research because it provides a way of understanding how the locations of actors are subjectively and socially negotiated as they become available to each other in interactions. In healthcare contexts there are a plethora of roles and identities that constitute care relationships and therefore are important in understanding how knowledge and meaning are constructed. Identity processes position people in interactions and therefore provide ideas about how power relations and standpoints may be operating in situations and how identity becomes a resource actively engaged for specific purposes. Two somewhat related aspects of identity processes were relevant because they capture aspects of identity represented in professional and organisational life. The first concerns social positioning and the second, identity salience.

Individuals and groups are socially represented when they conform to expectations of self and others by adopting certain perspectives, values and behaviours. The subjective and social processes of identity are in action here because as people are assigned a certain identity they are also located in the world and subjectively appropriated along with that world (Berger & Luckmann, 1966). People are positioned when certain elements of situations govern interactions. Stone argued that people attain an identity when, as social objects, they are positioned in social relations, that is, "one's identity is established when others *place* him (sic) as a social object by assigning him the same words of identity that he appropriates for himself or *announces"* (1962, p. 93).

The concept of positioning was relevant to the research inquiry because the intentional and strategic nature of this process offered a dynamic alternative to the static, formal and ritualistic way that roles are otherwise conceived (Davies & Harre, 1990; Elejabarrieta, 1994). The concept reflects how people cope with different situations and how these are open to negotiation and are therefore not fixed representations of roles (Elejabarrieta, 1994; van Langenhove & Harre, 1999). The social process of positioning therefore afforded a way of exploring issues around standpoints, power, choice and resources available to women, CHNs and midwives as identity was negotiated.

Identity salience is a concept somewhat related to positioning. The term extends the aforementioned idea of James' around the variety of social selves that people have as repertoires for dealing with situations. Salience reflects how identity is contextually negotiable because this process takes into account how power relations and access to resources influence identity. Identity salience is determined by the probability of various self identities being brought into play in a given situation or being invoked across a variety of situations (Hogg, et al., 1995; Stryker & Burke, 2000; Stryker & Serpe, 1982). In the identity hierarchy, the person identity is often thought to be of higher salience because it is the most relevant across groups, roles and situations and therefore most constantly activated in human interaction (Burke, 2004; Stets & Burke, 2000). A contrary view is that subjective identity is actually the most precarious (Berger & Luckmann, 1966) and perhaps least salient. The value of identity salience to this inquiry lies in the negotiated aspect of identity because this social process reflects how resources exist differentially in the healthcare context and therefore influence how identities are invoked for specific purposes.

Further aspects of the identity process pertinent to the research included identity processes such as social categorisation, typification and group identification. These processes reflect how the world is simplified by placing complex and variable things, like people, into categories so they can be dealt with more easily. For example, social categorisation refers to the process of grouping people based on equivalent actions, intentions or belief systems (Hogg, et al., 1995; Tajfel, 1978). Essentially, individuals are categorised or positioned as identity 'types' because this engenders stability in complex situations (Berger & Luckmann, 1966, p. 195; Hogg, et al., 1995). Identity types operate as conceptual machineries for dealing with situations because predictions can be made about present and future actions of those categorised. This mediates uncertainty, facilitates knowledge transfer and contributes to social order in complex systems. The processes also operate to sustain a desired status quo and contribute to prejudice and bias (Berger & Luckmann, 1966; Hogg, 2005; Hogg, et al., 1995; Tajfel, 1969). All of the processes highlight the complexity and unpredictability of human interaction.

Before returning to the research context and further points on the adopted philosophical position, some further relevant arguments around the construction of knowledge and meaning and the function of language are addressed below.

3.3.5 Language and the Construction of Knowledge and Meaning

Language is important in interaction because it is used to name or objectify significant things, events or experiences so they can be shared (Berger & Luckmann, 1966; Schutz in Wagner, 1970). Although behaviours are important to social processes, language (written and spoken) is afforded a vital place in shaping knowledge and meaning because language is the most fundamental process for capturing and transferring everyday knowledge (Berger & Luckmann, 1966; Burr, 2003; Gergen & Gergen, 2003; Schutz in Wagner, 1970). Language is a form of "social action" (Burr, 2003, p. 8) because as people engage in conversation they actively construct their worlds. In addition, language builds meaning because conversation brings reciprocity to interactions.

Language, pragmatic interests, everyday propositions and more explicit bodies of knowledge draw the world together so that it makes sense because things take on a certain order (Berger & Luckmann, 1966). The organising function of language symbolises significant things within social contexts that then gain specific contextual meaning (Mead, 1934). For Mead, the perfect and formal ideal of communication would be a world with a "universal discourse" (1934, p. 327). In reality, however, technical terms, jargon and dialects are known to demarcate groups when they are understandable only to those who participate in common experiences or traditions (Schutz in Wagner, 1970). Language therefore can divide realities, construct boundaries and build up semantic fields to create specific interpretive schemes that contest the notion of a shared world.

In exploring the concept of collaboration key tenets from the broad perspectives articulated above were engaged as tools to maintain a focus on social processes and to stimulate analysis. To conclude this chapter some final points of argument based on the philosophical position adopted are addressed.

3.4 RELATIVISM AND REFLEXIVITY

As argued, collaboration, as a human phenomenon, cannot be understood outside of a social dimension. The position of constructionism underpins an analytical interpretation of the object of inquiry as neither objective nor subjective but rather both. This is important because this research recognises that interaction and context are significant to the research focus. In other words, knowledge and meaning are constructed as people engage within the social world.

Conflicting views on this position have sustained debate about the relative/realist nature of constructionism. Crotty (1998) suggests that working within the position of constructionism requires reflection on the way in which research is done as much as how data is viewed. The idea is not to merely mirror 'what is there' as a straightforward representation of reality but to take into account how something is seen, reacted to and meaningfully constructed within a given situation and narrated through a particular culture (Crotty, 1998). This point is particularly important in engaging with criticisms of 'social construction' and of the supposed significance of social constructs (Hacking, 1999). The focus adopted here is on the process of meaning and knowledge construction and not primarily on the 'idea' that is constructed.

Crotty (1998) explains constructionism as assuming a somewhat relativist position because *'the way things are'* is really just *'the sense we make of them'* (Crotty, 1998, p. 64). Although relativists see no absolutes, Alvesson and Skoldberg challenge the idea that freeing the self from an empirical straightjacket by engaging in more creative approaches to research does not automatically give way to an "anything goes" approach (2009, p. 304). Relativists can and do acknowledge that there are a potential number of ‘relative truths’ that can be best understood in relation to specific contexts (O'Leary, 2007). Interpretations engage with different perspectives, contexts and relevances so there can be no single objective truth. Nonetheless and even though a number of interpretations are possible, this does not mean that the researcher has to treat interpretations as all equally good or ‘true’ (Alvesson & Skoldberg, 2009, p. 305). One interpretation can be accepted over other potential interpretations if it is recognised as contributing in a greater way to knowledge of a situation (Alvesson & Skoldberg, 2009). The responsibility for interpretation therefore demands much more of the researcher and here familiarity with a wide range of literature and viewpoints is necessary (Alvesson & Skoldberg, 2009). This was the position taken in this thesis.

A pragmatic approach to interpretation balances potentially endless reflexivity and scepticism with a sense of the research task at hand so that results are useful to readers and the context and advance knowledge in an area (Alvesson, 2011). Here lies the benefit in the analytical framework adopted in response to realist/relativist debates. First, the propositions and arguments presented are not intended to define an objective or empirically grounded truth but rather to understand a socially and culturally bound concept. Further constructionism does not profess to provide a final word on the object of inquiry but rather to encourage creativity and build dialogue (Alvesson, 2011; Alvesson & Skoldberg, 2009; Gergen, 2009).

The research engaged a range of key concepts and ideas to be applied in both research phases. Possessing a broad repertoire from which to draw for interpretation increases intellectual flexibility, receptiveness and creativity (Alvesson, 2011; Alvesson & Skoldberg, 2009). In essence, theoretical reflexivity flows through to analytical reflexivity when analysing and so the repertoire of tools derived from the sociological field discussed here were available throughout the whole research process. The convergence of the explanatory frame and the research methods is discussed in the following chapter.

3.5 CONCLUSION

The chapter has focused on making explicit the philosophical position underpinning the research and the key theoretical concepts that formed an interpretive framework. Choosing and making explicit elements of the philosophical position is an important step in situating the research because it provides a way to view the situation, to make sense of the concept to be explored and to guide the iterative process. This position guides the researcher and also the reader of the work by making explicit the assumptions embedded in the decisions made throughout the research process.

The chapter addressed theoretical perspectives derived from the work of Schutz, Mead, Blumer, Berger and Luckmann, and Goffman. Assumptions underlying the construction of meaning and knowledge were explored including the function of language in the process. Associated perspectives on identity were explained including social positioning and identity salience. These all provided interpretive resources and conceptual tools for the analytical work. Chapter Four of this thesis takes forward the theoretical lens to demonstrate how it informed the methods and shaped data analysis. The chapter proposes an approach to data analysis that represents a contemporary attitude philosophically consistent with the epistemological position of constructionism and the key thoughts outlined in this chapter.

Chapter 4: Research Method

4.1 INTRODUCTION

The central focus of the research was to explore the concept of collaboration as it appeared in the care continuum of transition from hospital to community care. This was achieved by working with data using four key processes drawn from the seminal work of Glaser and Strauss (1967); advances upon this by Glaser (1978) and developments in the evolution of grounded theory method that engages more fully with the philosophical position of constructionism argued in the previous chapter (Charmaz, 2006, 2008). In this chapter these four key processes for working with data are posed. An explanation of the research process, recruitment strategies, data collection and data analysis follows. Both phases of the research are expanded upon before the chapter concludes with the ethical and safety issues that were relevant to conduct the research.

4.2 FOUNDATIONS FOR ENGAGING WITH DATA

4.2.1 Foundations of the Research Method

The methods applied in the research drew on the foundations of the works of Barney Glaser and Anselm Strauss from the mid 1960s and articulated in their 1967 work *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser, 1978; Glaser & Strauss, 1967). At this time, Glaser and Strauss (1967) specifically sought to develop processes for managing data that considered sociological perspectives of situations and human behaviours. Their argument was that theory could be *discovered* or systematically worked out from data and in this way, theory was *grounded* in data (Glaser & Strauss, 1967). Grounded theory processes appeared at a time when positivist, objective notions of reality dominated research. Indeed, Glaser indicated grounded theory as a "general method" developed partially with quantitative data, although came to be linked more commonly with qualitative data and viewed as a qualitative method using symbolic interaction (1999, p. 842). It is perhaps due to the positivist influences in the early period of development that the original processes advocated by Glaser and Strauss consisted of a relatively prescriptive set of procedures (Jones, Torres, & Arminio, 2006).

Building on the concept of comparative analysis articulated by Weber, Durkheim and Mannheim; Glaser and Strauss (1967) described more fully how this method might be applied for the purposes of the discovery of theory in social research. In short, constant comparative analysis involved a process of sampling, collection, and analysis of data that occurred simultaneously (Glaser & Strauss, 1967). In their early work, Glaser and Strauss (1967) presented their method as a different way of working with data to ground knowledge. Thereafter the two authors pursued separate paths which saw slightly different positions on method evolve. Glaser continued to advocate a systematic, objective position on the management of research problems and data while elaborating upon theoretical sensitivity in the discovery of theory (Glaser, 1978). Meanwhile, Strauss focused on specific and systematic processes of coding by outlining open, axial and selective coding and applying structured frameworks to determine relationships between concepts (Strauss & Corbin, 1998).

The grounded theory method has continued to evolve and as such different interpretations have appeared. What actually constitutes a *bona fide* grounded theory remains ambiguous (Charmaz, 2011, p. 364). Greater flexibility in methods, while retaining the essential tenets for grounding theory, have been argued (Chamberlain, 1999; Charmaz, 2006). For example, the approach to grounded theory described by Charmaz links elements of classical grounded theory with an interpretive tradition and draws more directly on a symbolic interactionist perspective (2006, 2008). For Charmaz an abstract theoretical understanding of a studied experience could be achieved using grounded theory methods as a flexible set of principles and practices rather than a prescribed package of “methodological rules, recipes, and requirements.” (Charmaz, 2006, p. 9). This approach built on the pragmatist underpinnings of the foundational methods and shifted the interpretive tradition towards a constructionist epistemology (Charmaz, 2006, 2008). Developments such as this have freed the grounded theory method from the objectivist influences of four decades ago by bringing in more recent conceptualisations of human knowledge and experience. Importantly, Charmaz (2011) also argues that the grounded theory method provides the necessary tools for innovative analyses that afford a more critical stance when exploring concepts in new ways.

Growth in the application of grounded theory method within the social sciences reveals that a good proportion of this work is being done from an interpretive perspective (O'Connor, Netting, & Thomas, 2008). Conceptual clarity, however, is often lacking in research work on how methods fit with philosophical assumptions underpinning the research (O'Connor, et al., 2008). The method of data analysis adopted in the research challenges the uncritical adoption of ‘packaged’ methods that raise questions of philosophical congruence throughout the research process. As the focus moves to elements common to the achievement of theoretical understanding embodied by grounded theory principles rather than labelling work as ‘grounded theory’ the focus shifts from elements of methodological divergence highlighted by Strauss, Glaser, Charmaz and others to the articulation of a congruent research process.

Along with Charmaz, theorists and researchers including Bryant and Clarke have argued for the assimilation of basic grounded theory processes and contemporary methodological assumptions (Bryant & Charmaz, 2007; Charmaz, 2006; Clark, 2003). The argument is that flexible approaches to working with data do not compromise the analytic aspects of inquiry when they adhere to basic processes of method as adopted in this research and where the fit of method and philosophical positions and assumptions is a prime concern. The flexibility of method as argued above is further elaborated below.

4.2.2 Inspirations Drawn from Grounded Theory Method

The research adopts a more relativist ontology and constructionist epistemology. Unlike Glaser and Strauss, Charmaz (2006) assumed the view that neither data nor theories can be discovered; the discovery of theory as if it emerges from data separate from the influence of the researcher is no longer a ‘fait accompli’. The position argued is that no researcher can realistically lay aside what they bring to their research work as if it were an object to themselves (Charmaz, 2008; Crotty, 1998). So too the researcher cannot deny their own presence throughout the process of inquiry because qualitative research is a social activity. As such, data and theory are not discovered, but rather situations are *constructed* because the influence of the researcher is not only acknowledged but plays an important part in interpretation and the development of a theoretical understanding of the object of inquiry. In other words, “data are a *product* of the research process, not simply observed objects of it”

(Charmaz, 2008, p. 402). Proponents of this view argue that past and present perspectives, research practices and interactions with people, including research participants are brought to the research situation because they are perspectives that help see relevant data (Alvesson & Skoldberg, 2009; Charmaz, 2006). As Charmaz attests the theoretical results "...offer an *interpretive* portrayal of the studied world, not an exact picture of it." (2006, p.10). This attitude toward data links philosophically with the theoretical insights and perspectives argued in the previous chapter.

A constructionist approach to method advocates processes of collecting and engaging with data that are not strictly prescriptive (Alvesson & Skoldberg, 2009; Charmaz, 2006, 2008). The focus is on achieving reflexivity with the data and the research situation rather than a preoccupation with following set steps. This is important since one of the basic overarching principles of grounded theory method is the non-linear movement between sources of data. The point is that basic processes of working with data can be used flexibly rather than applied as a recipe (Chamberlain, 1999; Charmaz, 2006). Furthermore, the adoption of key processes from the tradition of grounded theory acknowledges that the social world is complex and thus a reflexive attitude toward the object of inquiry captures the dynamic aspects of the world. Flexibility affords a tolerance of complexity in data, to think and listen and look at data but also to create and construct rather than just 'do grounded theory'.

The current work adopts an innovative approach to method by drawing on the knowledge and experience of the aforementioned propositions while incorporating evolutionary concepts outlined above. Rather than considering the choice of 'which method' or 'interpretation' of grounded theory to adopt and thus adopting the label of a 'grounded theory' study, the research proposed a different view. The decision was based on the idea that grounding theory was a process that, although pluralistic, was nonetheless comprised of some basic tools that could be engaged creatively to suit the specific research situation. The aim was to utilise four key processes from the grounded theory tradition most applicable to the philosophical position of constructionism. A central idea is an attitude toward engaging the object of inquiry, self and participants that recognises reality as "multiple, processual, and constructed" under particular conditions, and embedded in interaction and interpretation

(Charmaz, 2008, p. 402). A critically reflexive dialogue with all sources of data thus allows engagement with a social context by drawing on personal, professional and academic spheres of influence and broader contextual influences including the political background to the research situation. Further, this recognises the social complexity of situations as different perspectives come together.

The method engaged for the research challenges the view that theory is discovered objectively, as first proposed by Glaser and Strauss. Further, this approach does not shy away from acknowledging that the theoretical understanding gained is an interpretation. It is not an exact picture, nor an autonomous theory in itself, because it depends on the researcher's view (Charmaz, 2006). The view that meaning is constructed rather than emerging from data locates authority with the researcher and participants who take responsibility for their beliefs (Freshwater & Avis, 2004).

4.2.3 Key Processes for Engaging Data

The principles of coding, constant comparison, theoretical sampling and memo-writing were the four anchoring analytical tools derived from the grounded theory tradition used in this research. Glaser (1978) described coding as the first step in shifting data from the empirical to the conceptual level. This process involves defining what is happening in the data by naming it, that is, statements in the data are assigned a defining name or code (Charmaz, 2006). The codes in themselves are a construction because they are influenced by the language, meaning and perspectives of the researcher and participants (Charmaz, 2006).

Coding begins the process of constructing tentative ideas to be carried across other data and compared. The ensuing processes are constant comparison, theoretical sampling of further data and generating ideas through writing memos. Glaser and Strauss (1967) explained constant comparative analysis as the systematic coding, analysis and theoretical sampling of data to develop theory. Here the researcher continues to theorise and return to data to confirm or redefine patterns and meanings as data collection ensues. Glaser (1978, p. 16) referred to the *"double-back steps"* between data and coding that depicts an iterative course. The process is thus much more than generating further data; it is primarily concerned with obtaining data that will conceptually and theoretically elaborate, refine and develop the categories in constructing theory (Charmaz, 2006; Glaser & Strauss, 1967). Glaser described theoretical sampling as the ‘prime mover’ of coding because it directs the researcher in deciding *where* to next look for further data, for *what* purposes according to the present codes, and *why* to look, as indicated by the ideas expressed in memos (Glaser, 1998, p. 157; Glaser & Strauss, 1967). Theoretical sampling does not mean gathering more and more data to find continuing patterns but rather purposefully targeting data collection to develop early tentative categories of data. Further, theoretical sampling involved using a full range of data including interview data, literature and theoretical ideas to construct further the developing concepts and categories.

Glaser (1978) attested that memo-writing should never stop in data analysis. Memos constitute a record of what is happening as ideas come to mind during data coding and comparison. In this sense they are pragmatically necessary to handle the complexity of data and to park ideas that may be needed at later stages of the interpretative process. Memos are a theoretical write-up of ideas about codes and their relationships (Glaser, 1978). The process of memo-writing facilitates abstraction by raising ideas beyond data description to a theoretical level, keeps the researcher actively engaged with data and focuses on the *how* and *why* questions needed to render thoughts (Charmaz, 2006). Memo-writing also develops other ideas by “plugging in” (Jackson & Mazzei, 2013, p. 261) with other data such as theory, literature, discussions with research colleagues and, as in this research, policy. Glaser was convinced that memo-writing was so vital that if the analyst skipped this process then “he (sic) is *not* doing grounded theory” (1978, p. 83).

4.2.4 Interpretive Awareness

Theoretical sensitivity is ongoing throughout data work and is required to remain open to what is happening in the data. To gain sensitivity means to be able to view data from multiple vantage points, to make comparisons, follow leads and build ideas along the way that probe and abstract in readiness to construct theory (Charmaz, 2006). As analysis and interpretation proceed there is both a rational and creative dialogue between evidence and beliefs achieved by critical reflection and construction (Freshwater & Avis, 2004). The constructionist stance acknowledges that data do not speak for themselves (Gergen, Lightfoot, & Sydow, 2004). Rather, the researcher is the tool here, conducting a dialogue with data to construct meanings. Theoretical ideas guide and facilitate this dialogue drawing upon literature, theory and the sociological field for interpretive tools.

The constructionist approach also recognises that the researcher's orientation or beliefs formed socially through past individual, professional and academic experiences *sensitises* them in making important decisions during analysis and interpretation of data and constructing theory. The ideas are reflected in the most basic processes of research such as choices to address certain questions and select certain codes as conceptual guides for further data collection and analysis (Glaser, 1978). The important task for the researcher is to find a middle path between, on one hand, forcing upon data preconceived notions and theories that may not readily fit and on the other hand, employing an eclectic use of concepts from various theoretical traditions that may not result in something that is ultimately meaningful (Kelle, 2005). The processes adopted in the research guided by well acknowledged research tools allowed this flexibility in interpretation.

Interpretation is engaged on two levels in this thesis. The first is within the research context as participants interpret and construct their worlds and the second is at the theoretical and analytical level as the researcher interpreted and constructed meaning of the situation as described above. A complex relationship exists between processes of producing knowledge, the various contexts of these processes, and the involvement of the knowledge producer (Alvesson & Skoldberg, 2009). Crotty makes it clear that "...at every point in our research – in our observing, our interpreting, our reporting, and in everything else we do as researchers - we inject a host of assumptions" (1998, p. 17). Awareness and engagement of personal knowledge and realities (assumptions, values, beliefs and pre-understandings) is possible and useful because the importance of interpretation in constructionism rejects the assumption that reality, empirical facts and research results simply mirror each other (Alvesson & Skoldberg, 2009).

As such, the researcher did not deny prior knowledge from past experience in nursing and midwifery, as a mother and from previous research, readings and discussions within the research community. This did not, however, grant free will to the researcher to construct come what may; rather it was managed carefully through reflexivity. In the words of Alvesson and Skoldberg this means:

> ...that serious attention is paid to the way different kinds of linguistic, social and political and theoretical elements are woven together in the process of knowledge development, during which empirical material is constructed, interpreted and written. (2009, p. 9)

The point is that interpretive awareness means the researcher is able to bring together different spheres of knowledge in a reflexive way because awareness of influences is inbuilt. Rather than encumbering the process this enriched the interpretive frame and provided necessary resources for creative thought while maintaining a concern for the theoretical understanding to be grounded in the data. The synthesis of interpretation and analysis through critical reflection becomes most critical in engaging with data so that understanding "is constructed through dialogue with the data rather than received from the data" (Freshwater & Avis, 2004, p. 9). Critical reflection is an intellectual task and as such "it *cannot* and *should not* be reduced to a set of formulaic criteria" (Freshwater & Avis, 2004, p. 9). This supports the view taken here that an uncritical application of objectivist methods encourages a reductionist approach to analysis in search of *a* truth which is fundamentally incongruent with the philosophical position argued in this research. It is possible to maintain discipline in the approach to data while entering a space to be in creative dialogue with data.

4.3 THE RESEARCH PROCESS

The object of inquiry in the research was the concept of collaboration in the process of transition between hospital and community care. The exemplar chosen for this work was the care continuum for women where their infants had spent more than 48 hours in a SCN. The research was conducted in two phases. Phase One involved conversations with women, CHNs and midwives to gain data on their perspectives of interactions within the care continuum. In Phase Two, the outcomes of the analysis of interview data were used to guide a deductive and theoretical analysis of the text from a broad range of healthcare policy documents to determine points of convergence and divergence.

4.3.1 Research Context

The social context for this research was a healthcare continuum. An example of a continuum was where women with newborns transitioned from a hospital setting to a community child health setting explored through the experiences of CHNs, midwives and women. To facilitate the collection of sufficiently rich data a specific context where sustained interactions between participant groups were most likely to occur was needed. The interactions between women, CHNs and midwives, where infants had spent time in the SCN fulfilled this purpose. Midwives and CHNs were recruited from three maternity hospitals, each with a SCN, and two community child health services. The child health services were those in the immediate area surrounding the three maternity hospitals. Women participants lived in this community area and all had infants that had spent more than 48 hours in a SCN. The context was a large metropolitan area in Queensland, Australia.

4.3.2 Research Participants

The overall sample for Phase One constituted 30 participants. The participants were sampled purposively, that is selected for the specific research task (Denscombe, 2007). The importance of purposive sampling is to identify information-rich cases or participants most likely to possess insight into the phenomenon of research interest (Jones, et al., 2006). The rationale was that the object of inquiry was described in the literature in many ways and was not well researched in the transition between maternity and child health settings. Furthermore, since the research was particularly concerned with exploring all perspectives on the research situation, it was important to collect data from key actors in this care continuum and to capture the interactions between CHNs and midwives, CHNs and women, midwives and women as well as the interactions of various forms occurring within the groups.

Not all CHNs and midwives working in maternity and community child health settings have direct experience of working with each other and with women and newborns during the early period of hospital discharge. Thus CHNs and midwives with this specific experience were invited to participate. The perspective of women, identified as a largely ignored area in previous research, has been addressed here. The sample was to include women with newborns who had spent more than 48 hours in a SCN based upon an assumption that this group of women was more likely to have complex needs that required specific action on the part of CHNs and midwives. As the research progressed, however, it became clear that the assumption that the term ‘complex needs’ referred to a defined group of women with babies admitted to the SCN was erroneous. Complex needs, as it turned out, were defined in many ways. Indeed, CHNs and midwives were of the opinion that all women could be considered complex. This point illustrated how previous assumptions could undergird research. Yet this was also a strength of the inquiry because it illustrates how assumptions could be challenged through the data collection and analysis process applied in the research.

In line with the reflexive nature of data gathering and analysis, the researcher sampled purposively to obtain maximum variation in data. As data analysis progressed purposive sampling of participants allowed the properties of early categories to be explored further. The sample of women recruited for interviews reflected a variety of experiences. The time infants had spent in the SCN ranged from one week to 91 days. Eight infants were born preterm and there were two sets of twins. Three women were from culturally and linguistically diverse backgrounds, eight were first-time mothers and one woman was a sole parent. The purposive sample of midwives included those who worked in the SCN, home visiting and other speciality areas of the hospitals involved in the care continuum process. Similarly, the purposive sample of CHNs brought a variety of experiences including those who worked in home visiting programs, child health clinics and involved in the transfer of care from the maternity services.

The number of participants in the research sample reflected the estimated number needed for a comprehensive exploration of the research situation. A variety of opinions exist on this subject and as such some guiding recommendations were used. Bernard and Ryan (2010), for example, suggest that 20-30 informants may be needed to identify the contents of a cultural domain although this number drops if those informants are knowledgeable on the topic. Similarly, Stern (2007) recommends 20-30 hours of interview data is often sufficient beyond which huge amounts of data can become overwhelming and difficult to manage. There was no way of clearly knowing at the beginning of the research what sample size would generate sufficiently rich data. Nonetheless, because the informants were purposively selected based on their known experience of the care continuum, a total of 10 participants in each setting was considered likely to provide a depth of data that allowed for a full analysis of the dimensions of the research focus. This sample was achieved with 31 interviews conducted. Using semi-structured interviews, the researcher gained the perspectives of 10 CHNs and midwives from each setting and

10 women. Thirty-one interviews were conducted because one participant asked for more time with the researcher. Women were excluded from the research if they were unable to converse in English or if they had indicated, during the consent process, that they did not wish to be approached for research purposes. There were no exclusion criteria for CHNs and midwives.

4.3.3 Recruitment Processes

The researcher attended staff meetings and other forums to discuss the research with nurses and midwives and follow-up emails were sent. Because the participant sample was purposive the researcher specifically extended invitations to community and hospital staff involved in the care continuum. Information sheets were prepared that outlined the research for potential participants and provided the contact details of the researcher (see Appendix A).

Women were approached by CHNs and midwives in the maternity and community child health services and provided with information sheets that explained the research. Consent was sought for the researcher to contact women via telephone to discuss the research. Standard National Health and Medical Research Council (NHMRC) consent processes were adhered to and specific consent forms were used to document informed consent (see Appendix A).

4.4 COLLECTING DATA

An important feature of the data analysis method was that the distinction between data collection and analysis was blurred because data collection was directed and informed by the developing analysis (Charmaz, 2006; Glaser & Strauss, 1967). The depth and scope of data was of fundamental importance and integral to the quality of the research (Charmaz, 2006). The open, inductive nature of the research meant that sufficiently rich data was required. To do this the researcher drew upon Glaser's dictum of "All is data" (2007, p. 1). Multiple sources of data provided diversity for comparative analysis and increased interpretive awareness and opportunities for the researcher to challenge assumptions made too early and to move interpretation beyond description. Interview data was obtained from conversations with participants in Phase One. Policy text was the focus of data analysis in Phase Two. Importantly, a third source of data accessed throughout the analysis was published literature. Finally, the researcher's knowledge and experience in the context and reflective conversations with research supervisors supported ongoing reflexive positioning. The data sources are elaborated further in the following sections.

4.4.1 Phase One: Conversations with Participants

Interview knowledge is relational, contextual and constructed (Kvale & Brinkmann, 2009). In other words, as a social practice, the qualitative interview is particularly sensitive to teasing out and constructing the nuances of meaning in terms of interaction and context (Kvale & Brinkmann, 2009). In the interview situation the interviewer becomes a conversation partner and socially, part of the construction process. As a purposeful conversation the qualitative interview is flexible and allows a spontaneous responsiveness to the participant that supports knowledge construction. Responsiveness generates depth rather than breadth of understanding (Rubin & Rubin, 2005) which was the intention in the research.

Language is a prime vehicle for exploration in qualitative research because it builds meaning through reciprocity and reflection. It is also particularly important because it can raise voices potentially marginalised by objective approaches to research (Gergen, 1998). In other words, seeking out voices elevates particular perspectives and experiences that may otherwise be unheard. This must, however, be stated with caution since language can also potentially limit inquiry if the individual, professional and geographical differences embedded in language are not acknowledged and reflexively managed. An example was the assumptions and language around complex needs as noted above.

Midwives, CHNs and women were invited to share their experiences of the care continuum by engaging in focused conversations in the practice setting, university or family home. Allowing participants to select times and venues for the conversations ensured shared power in the process. Flexibility was important since the conversations needed to be incorporated into busy lives without encumbering the participants and limiting discussion. For example, during several interviews women went about caring for their babies, feeding and soothing them and attending to other children. All of the women chose their own homes for the interviews.

The aim of the constructionist researcher is to engage intensive interviewing to ensure an in-depth exploration of an experience, while remaining flexible and sensitive to the interviewee (Charmaz, 2006). This is where interview guides supported the process. Three interview guides were used to plan the conversations using open ended questions (see Appendix B1-3 for complete interview guides for women, nurses and midwives). The prepared interview guides were functional for two important reasons. First, a prepared guide increased the researcher's confidence when entering the research conversation and second, allowed the researcher to focus on what was being said by the participant rather than on the questions ahead. Flexible use of interview guides also allow data comparisons across settings and between individuals without compromising reflexivity in the interviewing process (Bernard & Ryan, 2010). The interview guides were refined after initial interviews and revised throughout data analysis and sampling as coding became more focused, varied perspectives encountered and concepts refined. This non-prescriptive feature of questioning is important to the constructionist approach because it focuses on eliciting participant definitions of terms, situations, and events thereby tapping into particular assumptions and implicit meanings (Charmaz, 2006). The interviewer also needed to be self-aware by recognising and engaging the assumptions and perspectives brought to the conversation through the interview questions.

The interview guides consisted of initial, intermediate and ending questions as advocated by Charmaz (2006). Initial questions allowed the researcher to enter conversations where the participant could dominate by finding a safe place to commence. For example, the questions posed to CHNs, midwives and women initially focused on their everyday experiences as a way of getting to know the participant, finding a safe position to start and a focus on the object of inquiry from which to develop the ongoing conversation. A starting point was established on terms which allowed the participant to take the lead while open questions avoided a question and answer style. These terms allow conversations to unfold more freely.

Opening questions led into intermediate questions where the researcher identified areas to probe sensitively to gain greater understanding and to focus on a participant's specific experience. For example, CHNs and midwives were asked about information because this was a frequent conversation piece and a core code around knowledge work. Segues like this allowed the researcher to move to more focused questions. An example was the elaboration around the contradictions of complete and incomplete knowledge and concerns around needs and risks that were subsequently raised. The following illustrates a more focused question on this:

> *How would it be that someone would be a higher risk postnatal as to a low risk antenatal?*

During the course of conversations interesting ideas were noted by the researcher that provided the bases for probing further. In a similar example to the above, probing questions about how knowledge was ordered and how needs were reconstructed as risks gave insight into interesting contradictions around needs. The following probing question allowed this to be explored further with a participant:

> *...when you said you had an alert that something was not quite right with that woman so you questioned her more, how does it happen that this comes to your attention?*

Finally, ending questions brought the interviews back to a conversational level (Charmaz, 2006). The objective was to honour reciprocity and thereby share power with participants in remaining open to conversations on their terms. In conducting research much can be asked of participants with little attention paid to potential gains for those participants. Ending questions left conversations open for participants to ask something of the researcher if needed, for example:

> *Is there anything you would like to ask me before we finish?*

Women were interviewed within the first six to eight weeks after their babies had been discharged from hospital and following contact with a CHN. In all but one case participants were interviewed once.

Interviews and Data Storage

Interviews were recorded by the researcher using a digital recorder and transcribed to word documents. Early interviews were transcribed by the researcher and others were transcribed by a voice-to-text assistant. Non-identifiable, hard copy working documents were stored in a locked filing cabinet. Data were not labelled with individual details and therefore specific participants were unable to be identified from data (National Health and Medical Research Council & Australian Research Council, 2007). Electronic copies of data were stored on the researcher's notebook computer and university computer and backed up on the university home drive. Both computer systems were password protected.

4.4.2 Phase Two: Policy Sample

The central focus of Phase Two was to capture how the theoretical concepts and their properties, constructed in Phase One, were represented in the text of a purposive sample of policy documents. The focus of analysis here was based upon the adoption of a critical attitude to policy text that moved beyond analysing the content and implementation of policy to consider the values, interests and assumptions characterised through the scope, intentions and in particular the language of a policy document (Cheek & Gibson, 1997). Furthermore the focus is on how the concepts constructed with participants in Phase One were represented in policies around the time that the research was being conducted. For the purposes of the thesis healthcare policy was defined broadly as statements of intention or action made by public, private and voluntary organisations that have an impact on health and the healthcare system (Palmer & Short, 2010).

A range of individuals, interest groups, professional groups and associations, governments and media bring a variety of perspectives on the concept of collaboration to the policy process. For this reason a broad sample of Australian policy documents that encompassed prevailing views of nursing, midwifery and government were selected to provide sufficiently rich text for analysis. The researcher purposively selected policy documents based on knowledge of the specific professional and political area of inquiry that would allow concepts and their properties from Phase One to be fully explored. The policy sample comprised 25 documents; 15 were Federal government policies, three were State government policies and seven were professional nursing and midwifery documents (see Appendix C for the list of policy documents). A number of the documents were developed by consulting companies on behalf of government organisations and references were made therein to health consumers involved in the consultation and policy process. The policy documents were all published between 2006 and 2013, at the time just prior to and during the research process. All of the policy documents were available within the public domain. The aim was not to focus on a defined year range because the position taken here is of policy as process. As Colebatch (2005) points out policy is mobilised to shape practice in different fields and yet is subject to ongoing redefinition as the circumstances in which authority is exercised also changes.

4.4.3 Literature as Data

A further source of data for the research was published literature. This is important because literature is often conceived as evidence and fact. In this research, however, literature was a further form of data available to the researcher as an analytical tool. As explained in Chapter Two, previous research on the concept of collaboration reveals interesting assumptions that have previously been drawn in this area. This was important for formulating the research questions and establishing the researcher's position. Engaging with the literature also provided ideas that became important in working with data as the analysis unfolded and specifically during focused coding and elaboration of key categories and concepts. Literature supported reflexive positioning during data analysis because engaging with literature enabled the researcher to move beyond the context bound data to consider it within a broader social context.

There are various views on the timing of engagement with literature. Glaser's position reflects an objective stance although he did not deny the part that data from all sources played in inquiry. Glaser (1998) contended that reading literature in the area to be studied too early was problematic because it narrowed objectivity in much the same way that he argued the necessity to place aside or suspend preconceived thoughts. The position he assumed was to engage with the literature when the grounded theory process was almost complete, that is during sorting and writing up, as a source of data for constant comparison so that it was "woven into the theory" (Glaser, 1998, p. 67). This would ensure that concepts, hypotheses, properties and theoretical codes were discovered from data and were therefore grounded in data.

The constructionist position takes a different view in proposing that there is no one objective truth to be discovered from data. Rather there are multiple potential realities that are worked through with sources of data, using self and others to construct meaning. This position accepts that literature is data to be engaged with depending on the function it is performing at key times in the research process. Literature does not form preconceived ideas at the beginning of the work but rather can be used reflexively to position the work in the beginning stages of inquiry. It can then be engaged to work more closely with data to construct meaning as the research proceeds, for example, when undertaking focused coding and comparing data across sources. Other authors have similarly pointed out that the timing of engagement with literature depends on the philosophical position and the function it is performing (Charmaz, 2006; Giles, King, & de Lacey, 2013; McCallin, 2003). Ideas embedded across literary fields became tools for comparing, sampling and memo-writing and developing critical thought. Initial consideration of literature also functioned pragmatically to demonstrate a broad understanding of the situation and to fulfil ethical and thesis approval processes (Charmaz, 2006; Giles, et al., 2013).

Hence this research deviated from the traditional approach to a review of literature that justifies research by identifying gaps in current knowledge. Gaps are thought to generate ‘valid’ research questions and to indicate to the academic community that the researcher is on the right path. Yet the notion that a literature review reveals worthy gaps in knowledge to be filled is not unchallenged. Alvesson and Sandberg argue that “gap spotting” (2011, p. 247; 2013) in the literature and constructing research to fill gaps can restrict research if the assumptions underlying current knowledge are not challenged and are positioned uncritically within research. Taking ‘in toto’ what others have constructed and presented as gaps also risks taking the same assumptions forward or adopting a pre-determined path that limits inquiry. Research constructed like this may simply overlay existing concerns with new findings. Rather, literature encouraged a critical stance to the subject area from the beginning in indicating how gaps and assumptions had been constructed.

Hence literature functioned as data both at the outset and during analysis. This meant that the process of engaging literature included an initial contextual review and ongoing ‘literature as data’ processes during data analysis. That is, literature was data that functioned to work (with) other data. The point that St Pierre (2009) makes is that literature and theory are necessarily complementary to participant data. She argues that the ‘voices’ of participants are too often taken as sacred sources of knowledge and meaning and dominate research. The participants were but one manifestation of the social world of research and one resource on which to call for knowledge and meaning. Placing obsessive trust in the voices of participants as the most authentic data source risks eclipsing other data which results in “weak analysis and recycling of old ideas.” (St Pierre, 2009, p. 232). The social framework adopted here accepts that various sources of knowledge and meaning increase resources for theoretical sensitivity and constant comparison of data and engender more critical and theoretical expansion of the object of inquiry. The following section explains more fully the data analysis process.

4.5 DATA ANALYSIS

Analysis of data began in Phase One with transcription of interview data and continued simultaneously with ongoing interviews. Interview data were broken down into codes that were compared with other data to generate conceptual categories. The categories became the basis for the three key concepts, or theoretical abstractions, around the object of inquiry. The process of constant comparison was used throughout coding, sampling, memo-writing and theorising. The following elaborates the key processes of data analysis; coding, constant comparison, theoretical sampling and memo-writing.

4.5.1 Initial Coding

Initial coding involved closely studying lines of data from the interview transcripts. Attention to small segments of data allowed the researcher to remain as close as possible to the data while breaking it down into smaller units. This closeness placed some initial limits on the construction process since it separated data into general ideas using tentative codes. Initial coding was done with speed and spontaneity, looking closely at process and actions and coding with words that reflected the actions (Charmaz, 2006; Glaser, 1978). Glaser called this coding with "gerunds" (1978, p. 97) because verbs give a feeling of process, change and movement over time when conceptualising basic social processes. The preference for coding around actions and therefore processes was important to the philosophical position taken in the research because the focus was on social processes rather than naming and description. Charmaz (2006) reiterated Glaser's view by suggesting how this allowed data to be seen as sequences and connections more explicitly than coding by topic.

In the initial stages of data collection the researcher approached coding more methodically. The process became more spontaneous as a grasp of the situation evolved. This avoids making conceptual leaps and becoming selective with ideas and concepts too early in analysis (Charmaz, 2006; Glaser, 1978). The process kept the researcher moving with data while gaining insights from it. Speed in coding was not a concern at this stage since initial codes are always provisional; being trimmed, fitted and reworded as the process ensued (Glaser, 1978). The idea was that data, as codes, would never be static because constant comparison meant data were subject to ongoing scrutiny at all stages of analysis. During coding the researcher wrote on the transcripts, used highlighters and made notes on immediate ideas as memos. The principle was to cover the data as comprehensively as possible using line-by-line analysis to achieve as full theoretical coverage as possible (Glaser, 1978).

Three important questions were engaged continually during coding: what is this data a study of; what category does this indicate; and what is actually happening in the data? (Glaser, 1978). The researcher also drew upon other questions to hone in on processes and actions as suggested by Charmaz (2006) including: what process is at issue here; how can this be defined; how does this process develop; how does the participant act while involved in this process; what does the participant think and feel while involved in this process; when, why and how does this process change and what might be the consequences of the process? The questioning facilitated a critical stance during data analysis and formed a basis for memo-writing. This compelled the researcher to think about the data in ways that revealed contradictions.

The aim was to go beyond labelling or finding patterns in the data, to uncover ambiguities and processes that are key aspects of social reality and to engage with data as problematic (Alvesson & Karreman, 2011). Alvesson and Karreman refer to this as (de-) fragmentation or “an interplay between pattern- and fragmentation-seeking” (2011, p. 41) to support theoretically innovative work that moves beyond the surface to look for the less obvious or concepts less easily revealed in a quick decoding process. This way of working with data is different from most conventional approaches to data that aim to “order, control and domesticate what is studied” (Alvesson & Karreman, 2011, p. 43). The intention was to work with ambiguity and confusion by engaging preunderstandings, theoretical frameworks and various sources of data to ensure a more critical dialogue with data. The contradictions revealed in data through this process are illustrated in Table 1.

Contradictions in Data – The Two Dimensions of One Process

Following the Criteria/Process	Being flexible
Knowing what women need	Women need different things
We tell them	They don’t hear
Making up Stories	Finding it different
Finding Information	Changing Information
It takes Time	We Don’t Have Time
Empowering Women to ‘Own it’	We ‘Own it’
Working as One	Doing it ourselves
Getting them Back	Letting them Go
Being Informed	Finding out for Self
It Comes Down to Me	Sharing Responsibility
Being Transparent/Sharing	Concealing Information/Not Sharing
Being Organised	Going with the Flow
End of the Line	Continuing/Referring On
Asking for Information	(Not) Knowing what to Ask
Finding Needs	Managing Risks
Identifying Complex Women	Everyone is Complex
Abandoning women	Moving Women On
Having information processes	Finding information incidentally
Knowing my Role	Wearing Different Hats
Needing more Information	Working with What We Have
Deciding Priorities	Women Decide
Being the Expert	Partnering with Women
Being Known	Being Invisible
Having a Picture	Starting with on Open Slate

Table 1 Contradictions in Data

Reflection on the contradictions provided prompts for further analysis and theoretical sampling of data. For example, ‘Creating a Knowledge Order’ came to encompass how participants described the process of ‘Finding Information’ while also recognising ‘Changing Information’ that represented the constant struggle around managing uncertainty, overcoming selective sharing of information and negotiating knowledge boundaries. The contradictions were considered not as opposing entities but rather as representing two dimensions of the one process. This process was useful in constructing theoretical ideas about what the contradictions meant for participants; when, why and how they developed and changed, and the implications of this trajectory.

4.5.2 Focused Coding and Sampling Data

Focused coding involved working with initial codes so they became more directed, selective, and conceptual (Glaser, 1978). Focused coding began with synthesising and explaining larger segments of data than in initial coding and considering processes because social processes are more readily comparable across data (Charmaz, 2006). The most significant of the initial codes were selected as a basis for sifting through larger amounts of interview data. The selected codes were tested against the data to establish which made the most sense (Charmaz, 2006). Active codes were again used and coded data were tentatively constructed into categories to guide further data collection (see Appendix D for an example of early coding groups). Mapping out the codes in diagrammatic form proved useful in moving the ideas around and to visually construct where different categories might best fit within the overall inquiry and in relation to each other to construct final concepts. (see Appendix E for an example of one category ‘Creating Order’ which formed the basis for ‘Creating a Knowledge Order’).

As stated, one of the fundamental tenets adopted here was reflexivity in data collection and analysis. This means that although the above description of initial and focused coding appears as a sequential process, this was not the case. The researcher moved between collecting and coding data so that ideas were continually tested out and previous ideas were moved aside or reconsidered in light of new data or different viewpoints. Interviews were conducted over a 12 month period between June 2011 and July 2012 and data analysis and theoretical development continued for a further 14 months. Five interviews were conducted in the first three months to provide sufficient data as a starting point for coding and to test out the interview questions. Initial interview questions were refined with ongoing data collection as ideas were tested out with previous and current data. Furthermore, as coding progressed, the researcher continued to explore areas within the healthcare context where purposive sampling of participants would allow properties of the early categories to be expanded. For example, in different hospitals different midwives were involved in the care continuum and so when specific concerns were raised in data analysis this provided ideas on where to sample participants to explore the concerns. Concurrent engagement with published literature revealed different sensitising concepts to explore in ongoing interviews in ways that would develop concepts further. The experiences, actions and interpretations of participants were continually compared while also considering all data in relation to the broader context of the research situation. This included the ongoing theoretical development of ideas throughout Phase Two. Over a period of six months, 17 interviews had been conducted and early coding groups were developed. There were two further processes involved in working with data. The first concerned the construction of ideas by making notes of thoughts and ideas as memos and the second was the process of theoretical sampling. The following elaborates on memo-writing while theoretical sampling is addressed here and in the following section.

4.5.3 Memo-Writing

During coding and through constant comparison relationships and contradictions in data were produced. Thoughts developed spontaneously and fluidly. At times this was slow as it led into other data to test out ideas. At other times thoughts were generated freely and quickly, sometimes too quickly to note or coming to mind unexpectedly. Memos were used to ‘park’ issues in busy moments, to test out ideas with other data and to set aside ideas that might have been worthy of more considered deliberation.

Memo-writing started from the beginning of the research with simultaneous collection, coding and analysis of data and peaked during focused coding and in constructing categories as the researcher became more proficient in the process. Early memos recorded what may have been happening in the data as coding was commenced (Charmaz, 2006) and contributed to the abstraction of initial codes into tentative categories. Memos were dated, titled and stored as handwritten notes on loose pages in a folder. This allowed for sorting and would later prove useful in writing up sections of the thesis (see Appendix F for an example of an early memo).

More advanced memo-writing occurred during focused coding to expand the properties of categories and to make comparisons between them so that certain categories were constructed into concepts. In abstracting the codes to categories the memos challenged thoughts that helped define a category in terms of properties, the specifying conditions of its origins, maintenance and change, thinking of its consequences and importantly showing how it related to other categories (Charmaz, 2006). This allowed other data to be brought into the process such as literature that was not previously explored in the contextual review. Essentially advanced memos encouraged a greater level of abstraction. At this stage a map of the evolving thesis argument assisted in situating the categories and concepts.

4.5.4 Theorising and Reflexive Comparison of Data

It has been argued here that data needs to be ‘worked’ to arrive at meaning just as meaning is constructed as a result of active participation in the social world. Reading and engaging in personal exchanges increased interpretive sensitivity. Becoming familiar with a wide range of literature and viewpoints, as well as developing intellectual flexibility, receptiveness and creativity are important in reflexive methodologies (Alvesson & Skoldberg, 2009; Kelle, 2005). Theorising describes how the researcher worked with data during constant comparison. During coding, theoretical sampling, memo-writing and the write-up the researcher interpreted interaction between and reconstructed the situations of CHNs, midwives and women from a theoretical stance.

As noted earlier, theoretical sampling refers to how coding and analysis is used to determine ongoing data collection to ensure the process is guided by the developing analysis (Glaser, 1998). During this process the researcher returned to interviews and literature for ideas to elaborate and work the analysis. Sensitising concepts were useful because sociological concepts were new to the researcher and this process facilitated working with data in a way that was congruent with the philosophical framework. Questions of data at this stage were directed toward the interrelationships of concepts, how events and actions were changing over time and broader issues and events as indicated by the different sources of data.

In their original work Glaser and Strauss (1967) argued that theoretical sampling of data can stop when nothing additional is found to develop properties of the categories further. They argued that in seeing similar instances in the data over and over again “the researcher becomes empirically confident that a category is saturated” (Glaser & Strauss, 1967, p. 61). Dey (1999) contests this notion of theoretical saturation suggesting category sufficiency as a more appropriate justification for ceasing coding. The point here is that new ideas or perspectives can be revealed at any time in analysis and undermine or change previous constructions. This means that inquiry could hypothetically continue indefinitely.

The approach was to focus on coding to generate a theoretical understanding rather than to accumulate more and more evidence (Dey, 1999). This view is supported by Chamberlain (2000) and Charmaz (2006) who advocate using methods to interpret at a more critical level what is happening in the data, rather than managing data with set guidelines that sustain analysis at a descriptive level. Data was collected in the research until dimensions of the categories were sufficiently rich to progress theoretical thinking. The processes of theoretical sampling, constant comparison and memo-writing continued until three categories were adopted as core concepts. The key concepts are explained in Chapters Five through Seven of the thesis.

4.5.5 Data Analysis: Phase Two

The three key concepts generated in Phase One were used as a frame to guide a deductive analysis of the sample of policy documents. The analytical process sampled ideas around the properties of the core concepts using the aforementioned focused coding and data sampling processes. In a similar way to that described above, memo-writing and theorising were engaged throughout this phase. Other data sources such as literature were also used to explore theoretical points around policy processes.

4.5.6 Positionality and Data

As noted in the introductory chapter of the thesis, positionality is concerned with the relationship of the researcher to the participants in a study (Jones, et al., 2006). There were aspects of positionality also relevant to the data analysis process where it determined the selection of participants and policies, how the participants were represented and the potential influence on the researcher’s assumptions and knowledge of the situation (Jones, et al., 2006). The aim was to adopt an interpretive scheme that remained alert to multiple realities in a situation while actively seeking to identify *what*, *how* and perhaps *why* participants constructed meaning and actions (Charmaz, 2006, 2008; Gubrium & Holstein, 2008). The researcher’s knowledge of the context was an advantage because knowledge of the structure and processes in a research situation can give a beginning foothold on the research, although the relevance remains tentative (Glaser & Strauss, 1967). For example, researcher knowledge of the setting and context was beneficial in gaining access to the participants and in identifying relevant healthcare policies.

The process in the research involved continually collecting, coding and analysing data as explained above. Engaging with participants and assuming a reflexive stance in the research process meant looking critically to note what may not have been immediately obvious in data. The theoretical thinking continued into the writing up of the research. This is because writing is more than a “mopping-up” activity at the end of a research project; rather it is also a way of ‘knowing’ and a crucial phase of the analytic process (Charmaz, 2006; Richardson, 1994, p. 516). The advantage of writing and rewriting elevated the generated thoughts to a more analytical level, brought focus to a broader context and moved away from data and participants. This allowed the work to gain theoretical strength as the researcher grappled with more critical questions such as how historical and broader social conditions shaped the current situation (Charmaz, 2011).

The theoretical propositions recognised the influence of the researcher and interactions with participants in the specific context. Furthermore, because the emphasis was on process it is proposed that the findings could be relevant across other situations. This was explored in a move away from the immediate context as evident in the final theoretical analysis addressed in Chapter Nine of the thesis.

4.6 ETHICAL CONSIDERATIONS

The research involved human participants and therefore required ethical review and approval by the Queensland Health (QH) and Queensland University of Technology (QUT) Human Research Ethics Committees. In line with the “National Statement of Ethical Conduct in Human Research” (hereafter referred to as the

National Statement), a researcher is required to provide information to determine if research is ethically acceptable (National Health and Medical Research Council & Australian Research Council, 2007). The research was conducted in several QH sites and a single ethical review process for multi-centre human research was followed using the standard National Ethics Approval Form (NEAF) (Queensland Health, 2010). The purpose of the single approval model ensures research is ethically and scientifically reviewed only once by a single certified Human Research Ethics Committee (HREC) which acts on behalf of all QH institutions (Queensland Health, 2010). The researcher submitted an application to the QH Central Coordination Service. The application was allocated to a QH ethics committee and approval was subsequently granted. Authority to access specific QH sites was obtained following the Site Specific Assessment (SSA) process undertaken with the Research Governance Officer (RGO) at each of the five QH sites where the research was undertaken.

The research was also conducted in conjunction with the School of Nursing, Queensland University of Technology (QUT). The QH ethics process was pursued in the first instance and once approval was granted a submission was made to the QUT University Human Research Ethics Committee (UHREC) for an Administrative Review. The QUT UHREC is registered and accredited with the NHMRC to conduct research involving human participation (Registration #EC00171) in accordance with the National Statement. This application was also submitted using the standard NEAF. Approval was sought to:

- approach CHNs and midwives to provide information to women in the SCN on discharge or when attending the child health service,
- gain approval for CHNs and midwives to provide to the researcher contact details of women who wished to discuss participation in the research,
- contact women via a telephone call after discharge from the SCN,
- approach and recruit CHNs and midwives by attending staff meetings and via email using an information sheet, and
- interview women, CHNs and midwives.

The research involved a workplace and the possibility of impact upon workplace relationships was addressed during the ethics process. The prime concern of the ethics process as relates to human participants is to assess and facilitate the ethical conduct of the research and resolve challenges that may arise (NHMRC 2007). The research involved the work environment of the researcher. This meant that people in existing dependent or unequal power relationships could have coincidentally been recruited. There were two potentially dependent relationships in the research that were addressed in the ethics process. The first applied to the women who were current clients of the health services. The researcher recruited women by inviting CHNs and midwives to provide an information sheet to them in the SCN or in the community setting. This meant there was no direct dependent relationship between the women and the researcher since the researcher was at no time providing care to any participant. Second, the researcher was employed in one child health service team as a clinical manager. This meant that CHNs in this team could also have become participants and therefore a dependent or unequal relationship could have influenced participants' voluntary participation. To eliminate the potential for coercion and undue influence the researcher did not attend staff meetings for recruitment purposes at this site and was removed from the research situation during this time.

In line with standard ethics processes, all participants in the research were advised of their right to decline to participate in the research without any change in their employment conditions or relationships. These assurances were given and recorded in the Participant Information and Consent process. All participants were advised of their right to withdraw at any time without discrimination, reduction in care or relationship with the health service or any other comment or penalty. No inducements were offered to participants for recruitment to the research.

4.7 HEALTH AND SAFETY CONSIDERATIONS

A risk assessment process was undertaken to ensure the researcher was aware of, and responsive to, potential risks and/or hazards in all of the activities undertaken for the research. The two specific risks that were assessed for in the research were the health and safety of the researcher in workstation use including stress and fatigue management; and safety while interviewing participants in their homes. The researcher used a workstation on the university site that was adjusted appropriately.

Prevention of fatigue and stress was assured through self-awareness and reflection activities with supervisors and peers. The second potential risk was related to interviews with participants in their homes. A QUT Standard Operating Procedure applies to research involving visiting homes. To ensure that the researcher had addressed all potential risks, the appropriate forms were used to assess and put into place strategies required to minimise risks. These were submitted to the university parallel with the ethical approval process.

The researcher had 30 years of experience in working with women and families in the home setting. The knowledge and skills therein gained included an awareness of the safety and boundary aspects of professional practice which were an advantage in planning and conducting the research ethically and safely. Previous research in this context had provided insights and experience for planning the research. Processes for home visiting included a telephone call to the research supervisor just prior to entering a home and then a follow up telephone call after completing the interview. There were thirteen visits to homes and the remainder of interviews were conducted in office spaces.

4.8 SYNTHESIS: RESEARCH METHOD

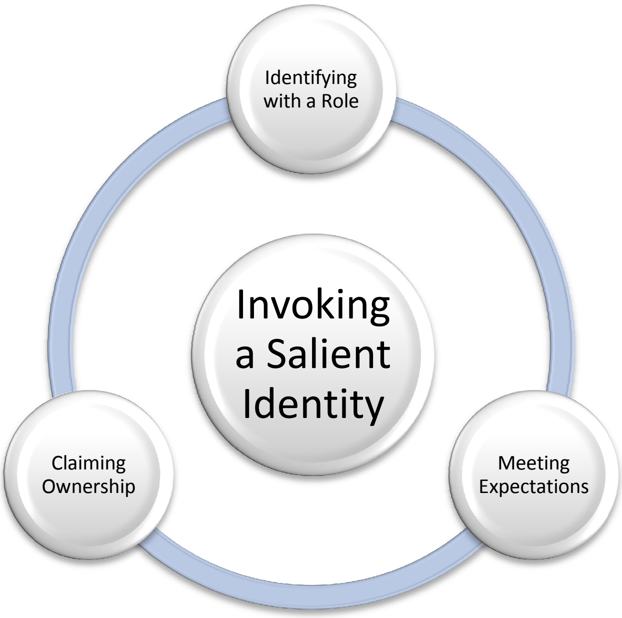
A most important consideration in determining research methods is that they can address the research question and that they allow for the research to be conducted ethically and safely. The above has articulated how the researcher engaged with the research data and conducted the research. Phases One and Two of the research were detailed in terms of the research sites, samples and recruitment strategies. The four key processes of data analysis, their origins and application, were explained. Finally, the chapter concluded with an outline of the ethical and health and safety issues integral to the safe conduct of the research. The following three chapters explore and explain the results of Phase One of the research and are organised around the three theoretical concepts generated and abstracted during the analytical process. Chapter Five follows to outline the first of the key concepts that concerns how identity shaped interactions and was important in understanding the concept of collaboration.

Chapter 5: Invoking a Salient Identity

5.1 INTRODUCTION

The analytical arguments posed here and in the following two chapters explore the conditions that constructed collaboration as an ambiguous, variable and contested concept in practice. The conditions are explored at three levels of social process; identity, knowledge and institutions. The first, identity, was an important element that gave meaning to the social situation of midwives, CHNs and women in the research. Identity is essentially a social process; the process of being objectively defined and subjectively appropriated within a certain world (Berger & Luckmann, 1966). To be identified as an individual and as a legitimate part of the care continuum were important aspects of the experience of participants. The concept of positioning was also relevant because it provided a way of understanding the intentional and strategic nature of identity (Davies & Harre, 1990; Elejabarrieta, 1994). Furthermore, the process of identity salience was contingent upon how participants were positioned by roles, ownership of resources and expectations. This was significant because while identity links people to each other and therefore to social systems, the process of identity was inherently precarious which suggests a strategic process of identity-making. It is argued in this chapter that control over the identity process was differentially available to participants. This was related to tensions in the social relations in the care continuum process that saw interactions take contradictory forms. The following figure illustrates the key properties of identity salience explored in the research.

Figure 1 Invoking a Salient Identity



5.2 IDENTIFYING WITH A ROLE

Midwives, CHNs and women intentionally and strategically managed interactions by positioning themselves and others through reference to role knowledge. Role identity, in turn, was significant in constructing some semblance of order in interactions within the care continuum. A CHN explained how role knowledge was significant in assuming a salient position in the care process through claims to a more holistic approach to the care of women and babies:

> I would say they (hospital nurses and midwives) are more focused on physical aspects of how the baby is doing, whereas I think child health nurses will focus on the emotional, the relationship, attachment, family dynamics, the support the mother has, how she is, even though I am sure the (hospital) is very focused on the mother's health as well. But I think it is more of a holistic approach that we look at. (C2)

A claim to knowing the whole patient was a way to position the role more favourably vis-á-vis other professional roles. Movement into psychosocial as distinct from biomedical aspects of care is integral to the professionalisation process in healthcare and illustrates how the expansion of professional roles occurs (Boreham, 2002; Conrad, 1992; Halpern, 1990; May, 1995; Salmon & Hall, 2003). Labels are applied to professions and roles on the bases of claims to particular knowledge and services and function to sustain professional boundaries (Nancarrow & Borthwick, 2005). Nurses, for example, describe practice in ways that contrast with medical practice by emphasising caring and holism and thus claiming a superior moral platform for the profession (Price, Doucet, & McGillis Hall, 2014).

A certain amount of knowledge exists in all societies as everyday knowledge, or, what any general person would be expected to know. Nonetheless, some knowledge is claimed more completely within specific domains and sits with distinct professional roles. The CHNs, midwives and women referred to both shared and discrete knowledge. For example, CHNs and midwives share professional knowledge of women and babies at the time of birth and up to six weeks postpartum. The issue, therefore, was not just about professional roles but the conditions around the legitimate use of knowledge as bound to a situational identity. The following reflect CHN views on the legitimate use of knowledge bounded and operational within certain roles:

> A couple of the girls have heard some of the midwives giving information that they think is more around what child health nurses would be giving. I think sometimes there is a bit of that. People get a bit defensive too like who's role is it to do that and are we losing our role as child health nurses as the midwives are giving more information. So it is getting that balance that is tricky. (C3)

> I have seen a couple of mothers who have had babies with trachy's at home and stuff and they kind of ask me lots of questions about like cleaning out the trachy's and doing suction and that's not part of my role as a child health nurse to talk about suction. (C7)

Yet, an alternate view is that knowledge boundaries were blurred and hence boundary crossing could occur. Participants were positioned as 'knowing enough' to justify crossing knowledge boundaries to meet the needs of women and facilitate the care processes. The blurring of knowledge boundaries was described as making processes easier where access to certain staff was difficult as explained here in relation to access to CHN knowledge in the hospital setting:

> Before we had the discharge facilitator role we used to call the child health person from (other hospital) but that got a bit awkward so it's much easier

> now with the discharge facilitators. They are all midwives. I guess they're not child health nurses but they know enough. (H7)

Knowledge boundaries were important points in the identity process because negotiations in this shared zone sustained not necessarily the boundary as a fixed symbol, but as a tacit order to the system. In these zones, limited boundary crossing was possible and indeed acceptable but was nonetheless conditional. Lillibridge and colleagues (2000) argued that the negotiated aspect of knowledge boundaries occurs along a continuum from maintaining one's comfort zone, expanding into safe territory, moving into shared or 'grey zones' and thereafter stepping over the line. Interaction in the current research rested upon an understanding of implicit rules about the use of knowledge including how, when and by whom knowledge could be legitimately used. The following indicates that shared zones existed around roles although with conditions on knowledge use:

> ...occasionally we get mums in where they're postnatal or they're pregnant and they've got a toddler and their mood is being impacted upon by difficulties managing the newborn or the toddler then that's out of my scope of practice. I am happy to do a bit around the edges but as soon as it's like (that); no that's a bit much. (H7)

Conditions for boundary crossing and hence role blurring are set up in complex social systems such as healthcare because the highly specialised divisions of labour construct knowledge dependencies. Shared knowledge and therefore a blurring of role boundaries had an important function where CHNs and midwives needed to know *about* the knowledge of others to make the care continuum work. For example, a certain amount had to be known about the roles and knowledge of others to deal with emergent situations such as staff shortfalls. Thus while knowledge was bounded, the capacity for role blurring was important where resources were limited as one midwife explained:

> I just can't abandon them, I mean send them home and tell them to come back next week. What are they going to do for a week if we haven't given them some sort of assistance with support? That's why we need to wear many hats as midwives. As I said a good example is if the social worker is not available I just can't send you up to the social worker so I have to put my social worker hat on and think what am I going to do with you today? (H8)

Fournier (2000) proposed that rather than conceiving of knowledge boundaries as fixed realities, they should be understood as malleable and expandable. She explained how the field of professional knowledge is always in motion, self-producing and self-expanding so that the object it claims to know is not independent of the professional gaze, but constituted by professional practice (Fournier, 2000). This means that knowledge boundaries are constructed and engaged strategically to invoke desired identities with different purposes. Hence, while CHNs and midwives could put on different knowledge 'hats' to deal with the unexpected, this had consequences for interactions. In other words, where people present themselves as "all things to all people" (Stapleton, 1998, p. 15) this sets limits on other roles. This midwife explained:

> Women need to see midwives because we give them the information to support them because we pick up their psychosocial needs. Doctors are very good but they'll come and they'll ask what do they do and we generally take over because we've got all the information. (H8)

Similarly, approaches that claim to be holistic as indicated previously, represent women as a whole and yet CHNs and midwives also claim sole responsibility for care of women in the name of holistic care. Knowledge therefore becomes a resource that can be manipulated to increase the relative status of roles representing power and control. While collaboration implies the blurring of roles and knowledge to facilitate care processes divergent meanings are concealed.

The existence of a hierarchy of roles, explicit in the language of participants, challenged knowledge plurality with consequences for interactions. Those positioned higher in the hierarchy were considered to have more specialised and valued knowledge than others. Positions were propagated and entrenched by those identified as 'needing to know' because of the assumption of a dominant professional hierarchy. The following woman indicated how a hierarchy of credibility existed:

> It's different hearing it from a doctor. The midwife would have relayed it fine but I guess the doctor, they're the ones that have done all these tests and they're the ones that the midwife calls if they're not sure of something and if something goes wrong. (W7)

The role hierarchy is contingent upon social, political and professional factors that arise as threats to identity. Child and family health and maternity care, for example, are becoming increasingly specialised which has opened up different options for healthcare consumers. The boundaries around professions and between roles in nursing and midwifery have also become increasingly vulnerable to both unregulated care-providers (Thompson, 1997) and expanded roles such as Private Practice Midwives and Nurse Practitioners. Governments too are opening up public sector healthcare to market competition in the interests of cost saving while proposing greater choices for healthcare consumers (Queensland Health, 2013). Professional education has also changed so that generic professional knowledge and competencies are "transportable" and linked with individuals rather than work roles (Windsor, Douglas, & Harvey, 2011, p. 1).

This means that professional monopolies over roles and knowledge are being continually tested. As such healthcare reform and the restructuring of nursing and midwifery have caused a shift from overbounded systems where goals, roles and responsibilities were clear and rigid within hierarchical reporting lines to underbounded systems where lines of authority and accountability are blurred (Chiarella & McInnes, 2010). Midwives and CHNs are acutely aware of the tensions as threats to identity. For example, numerous barriers exist in relation to midwifery roles including lack of opportunities to enact the full spectrum of maternity care, medical dominance, workforce shortages, the institutional system of maternity care and the absence of a clear image of midwifery (Homer, Passant, et al., 2009). The following indicate how CHNs and midwives drew attention to how changing social norms threaten professional identity:

> I think sometimes clients don't really know who we are and what we do and probably midwives don't either. So I think we need to sell ourselves more as well, as a profession. (C3)

And:

> In this last generation women have got out of the habit of attending child health clinics. They're no longer the cornerstone of motherhood as they used to be and I think they (CHNs) need to make themselves more visible, more popular, more accessible, because I feel they have a very, very important role. These days there's a big shift towards privatisation. Women tend to follow up independently at the chemist or a midwife and clinic somewhere, perhaps at a local chemist. They do their own thing and it's really more

> convenient, you're doing the shopping, you nip in and see the midwife at the chemist. But I think it's good to have that framework, that consistent framework of an agency. (H10)

The social world tests the bounded nature of knowledge in other ways. For example, women report consulting friends and families for parenting advice (Gildea, Sloan, & Stewart, 2009; Heinig, et al., 2009) and finding it more convenient to access advice outside mainstream healthcare services (Maher, Hughes, Anderson, & Lowe, 2013). The social nature of knowledge contests the professional view of hierarchical models of information exchange and knowledge bound roles. The following is an example of how women tested out professional knowledge:

> ...he actually had a blocked tear duct in the first three weeks, pus and all kinds of stuff and his eye all swelled up and I looked on the internet and they had information you know that said if it's a blocked tear duct warm water, cotton wool, brush it over and it should clear up by itself and if it's not well within a week go to your doctor and get some medication, eye drops and stuff like that or you might need a surgical procedure to be done to his tear duct. And I thought oh my God and then I rang the 13 Health and they had basically the same information but it was a shorter period of time. So it was keep doing the warm water with the cotton wool, keep bathing his eye, keeping it clear, if it's not better by Monday take him to your doctor. And I was talking to my friend via text and told her what was going on and she came back and said "put some breast milk in his eye."....She has had two kids of her own and I said "OK". I tried that and within five minutes his eye was open, the pus was gone, it was not swollen anymore...it was really strange. (W2)

Yet professions endure as reference points suggesting how strongly socialised people are to the hierarchy of professional knowledge (Becker, 1967). As noted, a key concept of professional identity is control over certain knowledge and skills (Boreham, 2002; Burns, Schmied, Fenwick, & Sheehan, 2012). Here, the term 'expert' was important in interactions depicted by CHNs and midwives because it functioned to position people in the role hierarchy. This was despite the fact that expert positions shifted in the research context. For example, CHNs, as distinct to other professionals, claimed professional knowledge on parenting and the community within the province of their role. Parents, however, were also positioned as experts on their situation and their children depending upon whose interests were being served. The following illustrated the shifting position on expert identity around knowledge:

> I think to read the referral and to try and have as much information as you can have. So don't skim it, read it properly because you are not going to know everything and parents are the experts in their children as far as I am concerned, or what has happened to their children because they have got a vested interest. (C7)

It has been argued that redefinition of the expert role reflects a shift away from medical dominance whereby patients are positioned as partners in healthcare where choice, self-management and active engagement in health are valued (Bury & Taylor, 2008). Redefinition also reveals divergent ideologies. For example, partnership in care advocates that professionals assume a 'parent advisor' rather than an expert role on the grounds that professionals need to acknowledge the competency of parents (Davis, et al., 2002). The reconceptualisation of the expert role is made in the name of partnership and greater collaboration. Yet others interpret the shift as competition for scarce health resources where governments define patients as experts to shift responsibility for health (Alaszewski & Brown, 2012; Bury & Taylor, 2008; Prior, 2009; Veinot, 2010).

Nonetheless, the shift of expert identity, to recognise women as more knowledgeable and participative in their care, limits professionals in their roles and challenges professional identity (Larsson, Aldegarmann, & Aarts, 2009). Shifting ideologies have thus consequences for professions and have given rise to alternative ways to reaffirm role boundaries. Fournier points to the constant work that professionals engage in to maintain and re-create boundaries as "boundary work" or the "labour of division" (2000, p. 73). Professionals as 'experts' assert themselves by claiming authority over discrete bodies of knowledge, defining a certain reality and by claiming to know the ultimate significance of what everybody knows and does (Berger & Luckmann, 1966). Even so, Fournier (2000) argues that professional positions are always uncertain, they require constant attention in ensuring confirmation of knowledge as significant and credible by others. The CHNs and midwives engaged in boundary work by making claims to knowledge as part of an active positioning process. The following are examples whereby the definition of significant knowledge acted as reference points in the preservation of professional identity:

> I'm a midwife but I would be better than a midwife because we (CHNs) are looking at different things to what they (midwives) look at....I think we look at the family unit more. They go in and they do the postnatal check and things like that but I think we are actually more community focused and we get the mothers linked into community services much quicker and whatever else they need. I think they are good, don't get me wrong they are very good in that first 5 days but we are more longer than that. (C10)

> We are midwives (and) we need to have the professional rights to be able to refer women, not be waiting for a doctor to refer them, and the doctors are more than happy for us to refer them. We are the ones seeing them, we are the ones giving them continuity and we know what their needs bases are and what services they would need. (H8)

Boundary work focuses on creating a demand for one's role and dependence upon discrete expert knowledge. Professions preserve dominance by sustaining the demand for specialised services (Nancarrow & Borthwick, 2005). To do this CHNs and midwives engaged in boundary work by acquainting women with the rules and conventions around legitimate use of knowledge associated with professional roles. Key points at which women are considered more receptive to this socialisation are the antenatal period and during first visits (de la Cuesta, 1994). The health professional participants actively asserted the significance of their positions through women at these key times. This was achieved by overtly positioning women and suggesting how women could self-position in relation to health professionals. The following indicates how women were engaged in this process early in prenatal care:

> ...it's a Doctors clinic but we see them as well. And we tell women "if you want to see a midwife, when you present to the counter for your appointment you ask to see a midwife." It's not necessary that they have to see doctors. (H8)

Monitoring of role boundaries was therefore critical. Some of this was self-regulatory and involved a cautious movement into the domains of others. Yet knowledge was also monitored in other ways as a form of control. For example, women at times would be in contact with other professionals and became unknowing accomplices in the monitoring process when sharing experiences with CHNs and midwives. The following exemplar demonstrates how such monitoring functioned:

> Sometimes you get conflict because you might have say a family support service going in (to see a family) and they were talking about children feeding, meal times, which is great that basic parenting stuff. The parents really lacked those skills, but the information they were giving for the 4-5 year old was not really appropriate for the 4 month old. So I was interested to find when the parents were saying to me "Oh the lady said to give this, this and this"....But what they were giving wasn't particularly ideal. It was ideal for the 4-5 year old but honey on toast probably not ideal for a six month old...I am not saying they have got to talk to me all the time but really when it comes to the little ones, I would say that I would probably give them information on that as well. So that's where you are not collaborating really. (C7)

While role knowledge had an important function in identity salience and was often ambiguous, giving different forms to collaboration, claiming ownership of other resources was a further dimension of identity that shaped interactions. This second dimension of the identity process is explored below.

5.3 CLAIMING OWNERSHIP

Ownership of resources had a central function in identity processes because resources defined and legitimated the positioning process that shaped interactions. Resources are not considered here as entities in themselves but rather social products that sustain interactions and give meaning to the ways that people act, just as Mead described the function of objects (Blumer, 1966; Burke & Stets, 2009; Freese & Burke, 1994; Stets & Cast, 2007). In interactions the CHNs, midwives and women sought to invoke a desired identity through claiming legitimate ownership of socially significant resources. This meant gaining control over resources of value so that a certain pattern of interaction could be sustained. The baby was one such resource.

Where babies entered the SCN unexpectedly and very soon after birth, health professionals assumed control, making decisions and setting priorities based on expertise. This was justified as necessary where the women were not available or to protect the women by relieving them of the burden of decision-making. The symbolic nature of the baby as an object of health professional expertise in the SCN meant that women were positioned outside the immediate situation. This was justified as a means to allow nurses and midwives to stay focused, a situation that has been identified in similar neonatal care contexts (Trajkovski, et al., 2012). Control over the positioning process was explained by one midwife:

> The things that I found upsetting were the fact that because of the medicalisation of what had happened because the child was sick, the parents tended to be excluded, decisions were made without them. The necessary stuff like having to do lumbar punctures and that sort of thing. It was distressing to see the child taken off the parents, be as it was dictated, it couldn't be helped....Sometimes it's easier to block parents out when you're dealing with a very sick child. You tend to focus on the child and not the parents but it's important to bring them in and to have them there. It's not easy to cope with them, which is why we do it. We block them out because their pain is so real... (H10)

The symbolism of the baby as the object of professional care meant that the baby was the key focus of decisions and attention. Women rationalised the necessity of this positioning while also wanting to establish identities as mothers with control of their babies. Limitations on control of their babies was perceived by women as reducing both personal and role identity. This woman described the adjustment to this positioning process in the SCN:

> It felt pretty awful for a little way and it's kind of like "no, hang on I'm mentally here in this moment with this place and this little space, right, now I've got to adjust and create my own little mental space here with my apparent baby." (W10)

The right to be heard is differentially distributed in hierarchical systems because those at the top have greater access to information while those lower within the hierarchy are socialised as morally bound to accept this (Becker, 1967). It is argued that a similar process extends to identity salience since ownership of resources legitimate the authority of health professionals to act and to position others in ways that constrain roles. Being constrained from control of their babies meant that women were limited in how they could participate in care. Similar findings elsewhere demonstrate how women work hard to assert some authority and claim ownership of their babies in neonatal nurseries (Fenwick, Barclay, & Schmied, 2008; Lupton & Fenwick, 2001). As such there is potential tension where neonatal nurses, on the one hand, want to partner with parents and have them involved and, on the other hand, retain some control (Trajkovski, et al., 2012). Limited control in the SCN diminished the maternal role and meaning in interactions so that actions became ritualistic as one woman described:

> It is kind of really blurry it is just because you are just go, go, go and like I remember you know all the interactions with the midwives and feeding and going in and going out and doing all of that, in a sense I was just on automatic pilot. It felt like they weren't my decisions in a way. (W2)

Exclusive ownership claims could also be engaged strategically to limit roles, to secure a preferred definition of a situation and to avoid scrutiny. It might be assumed that CHNs and midwives are equally situated hierarchically and therefore motivated to share resources and decisions. Yet shared ownership implied more work. Exclusive ownership, on the other hand, reduced work associated with negotiations and avoided the need to monitor agreements that were unreciprocated, inequitable and difficult to 'enforce'. The following illustrates how midwives saw that ownership of decisions in the care continuum reflected control over situations, reduced conflict and allowed desired outcomes to be achieved more readily:

> ...they were saying "oh we don't have the resources to do it." So we had a meeting with (service) and we decided we would just follow up our own women from then. And since then it has been much easier....So it works much better now and we don't have any reciprocal agreements with anywhere. (H5)

> They (hospital department) had some very definite ideas about things and we actually didn't agree on a few things....I am more than happy to (take it over) then I feel confident that it is completed because (midwife) and I are in charge of it. (H1)

As the above indicate, unilateral ownership functioned strategically to set limits on others and was justified as a means of getting things done in a timely manner and to avoid conflict. Similarly, situations where ownership was unclear were also considered problematic by participants but in different ways. One reason was that ownership indicated a legitimate position for a person, that is, an identity *in terms of* the care continuum. The process of being 'unowned' for women meant exclusion from a legitimate position and therefore a meaningful place in the care process. This woman explained how ‘rooming in’ elsewhere in the hospital while the baby was the focus in the SCN reduced identity salience:

> It was just the whole like forgotten, tucked away in this corner. “No you can’t talk to the people at this nursing station because you are not a patient on the ward for these people.” If you have a problem you contact us sort of thing and yeah I don’t know I didn’t feel like we were sort of...well I was scared. (W3)

Yet, where women took ownership and control of their situations this constrained the position of CHNs and midwives. The example of child protection, as raised by CHNs and midwives, is pertinent here. The CHNs and midwives determined where a situation was of concern and in need of monitoring and so if women did not engage with services this became a problem. The following revealed how CHNs and midwives defined the ‘unowned’ as problematic so that action was required:

> If they (the women) don’t seem to be with anyone then we will do a notification to child safety that they’ve got a lot of risk factors and they are not engaging with anyone. (H3)

> ...we have got a system in place if they (women) decide they want to link in to their GP or whatever. Then we can talk to mum and send on a summary to the GP, we do a GP transfer. (C9)

Discrete ownership claims were ever present even though a language of working in partnership and shared decision-making co-existed. Practice around child protection is seen as one situation where professionals are impeded from implementing partnerships because of the conflict between relinquishing professional ownership and the prevailing risk averse culture (Morrison, 1996; The Allen Consulting Group, 2008). Professional accountability was continually and disproportionately invoked by CHNs and midwives in the interests of pre-empting problems such as child protection. Furthermore, certain professionals within the care continuum were positioned with greater ownership of responsibility as exemplified by this midwife:

> You know it is really down to me what happens to the women when they leave, what contact they get and what follow up they get. So I think it is quite a vital role. (H5)

Who later reinforced with this point:

> My job seems to be the end of the line so that all of the things that don’t get done coming through antenatally all the way through land on my desk and I am like “Oh I will do that shall I?”(H5)

Claims that functioned to set down clear ownership boundaries often rested on this accountability argument. This suggests that risk averse situations, for example around child protection, drive unilateral ownership models. Professional definitions therefore reinforce the dominance of health professionals and contest the idea of a care continuum focused on women and babies where care is determined by the needs and priorities of women. In other words, ownership claims reify professional boundaries that reject, if implicitly, the whole idea of a care continuum. This has been confirmed elsewhere where services focus on who a woman client belongs to so that co-existence of midwives and CHNs in the postnatal period is not mutual but monopolistic (Homer, Henry, et al., 2009). Similar sentiments are reflected in the following where ownership shifts responsibility and constructs boundaries based on professional practice rather than the needs of women:

> ...it’s (the maternity service) responsibility to follow that through because we haven’t actually engaged with the client; it’s still their client... (C5)

> Our role (midwife) is really concerned with that postnatal period of up to two weeks after the birth or discharge from hospital, and after that child health take over until the child goes to school. So they are necessarily two separate areas. I would not be involved in a long term support of a young mother because I have other responsibilities and that is the role of child health as I see it. (H10)

Ownership claims, where women, babies and families were identified symbolically as objects of professional attention sit uncomfortably with assertions of child, woman and family-centred care. For midwives, the women were predominantly the focus of care, in the SCN the babies were prominent and for CHNs children were largely defined as clients. This positioning process was significant to professional practice where claims were not always about the care continuum but rather the legitimation of professional practice. For example, midwives argue that ‘case load midwifery’, engenders greater autonomy and responsibility for individual women, while this also results in prestige for the profession and satisfaction for individual midwives (Hunter, 2006; Stevens & McCourt, 2002). Nurses also claim patient-centredness as a means of constructing professional hierarchies whereby dominant positions can be legitimately claimed (Gachoud, Albert, Kuper, Stroud, & Reeves, 2012). The following explain how ownership claims defined professional practice:

> And now that midwifery is centred around family, it is not just centred around that woman like years ago. When you and I were having babies it was all about us, it wasn’t about our family at all but now it’s the family. Its family focused and it has got to be because of the psychosocial support that’s required. (H8)
>
> ...the child is our client but obviously the family is what we look at. (C9)
>
> I noticed with a lot of the nurses that were in the special care nursery, I don’t think they were midwives, and I think that it was just all about the patient which was the baby and you are just in their way stopping them from getting their job done (W3)

Control was predominantly defined and controlled on health professional terms. The following demonstrate how women were unaware of the implicit rules that governed the shifting ownership process as defined by professionals:

> I didn’t realise this until I got home, she said “you still belong to us until you’ve had that first appointment (with child health) so you can still ring special care and get advice and things like that.” (W1)
>
> We basically were just left to it really and the second day they came and said “We’re waiting for you to tell us when you’re ready to go home.” So we thought alright, we can go. (W6)

Overall the concept of ownership reinforced and invoked a salient professional identity in ways that limited the self-directed participation of women. Further, shifting ownership was an ambiguous process. Similar contradictions around identity processes concerned how participants were positioned through expectations. The following explains this further dimension of identity salience.

5.4 MEETING EXPECTATIONS

Healthcare institutions exert significant control over individual action through legitimate power which is continually reaffirmed as people act according to expectations. This means that healthcare institutions, through the use of authority, pre-define how people will act in ways which go largely unquestioned particularly by those with least power and control. Women were socialised to expectations and rationalised this positioning as necessary to the situation. As Moscovici suggests, people are positioned in ways that confine them to sets of “linguistic, spatial and behavioural constraints” and by formulating demands based on expectations, influence is brought to bear (1984, p. 31). Those in less dominant positions are socialised to this process and have less success in negotiating expectations which narrows options for individual action. The following indicates how women were subject to certain pre-determined demands:

> I didn't want to tell them (in SCN) that I was sick. Because like I said earlier, they made me feel guilty about not getting with the program and things.... Because they can do everything including nappy change, feed and putting them down to sleep in 45 minutes. I couldn’t do that let alone like feed. It took me longer to feed and do all that stuff. So by the time I'd probably have them (the twins) settled it would be well over the hour and then they would have to start (again). Because they timed it from the time they (the twins) started feeding, not the time I finished, and then probably on the second, third day I tried to just not fart around too long and just got on with it. (W5)

Hogg (2005) contends that people are fundamentally motivated by the desire to know about their position in the world which includes knowing how to behave and knowing how others are expected to behave. Expectations function like this to alleviate uncertainty and guide actions through an assumed order. Narrowed options for individual action, through construction of expectations, were justified to make the care continuum work, for example where imperatives around timeframes existed. Yet, where expectations were neither shared nor negotiated interactions, while framed as working together, were more often coercive. The exemplar below suggests how expectations were communicated to women to invoke compliance because this was necessary for the care continuum to work:

> ...if you communicate to the mothers fairly early on what's expected for parentcrafting they do get the idea what's involved so they will participate much more easily. It is much easier to get them involved in all their care and all that. If you don't let them know then they won't turn up for visits, they won't do feeds and then that delays the (discharge) process. (H2)

In the SCN women were expected to perform as mothers such that their personal self was positioned secondary to the baby's needs and associated contextual demands. This is how role salience was constructed. In other words, the distance between self and role became narrowed so that women were most often identified in terms of maternal role performance. The following exemplars demonstrate how women understood this process in the SCN context:

> The special care nurses were very focused on the baby and that was great because that's what she needed too but they weren't there too much for me except just to say "you're doing a good job"....They were very routine focused the special care nurses they were getting on with their routine and I fitted in with the routine. (W10)

> They are trying to get you into mother mode. They are trying to click your head into this is what you need to do; this is your responsibility if there is no one else to help you. (W2)

Participants, to assume a favourable position, adjusted actions to deal with the expectations imposed upon them. The CHNs and midwives possessed more power in the process because of knowledge of healthcare institutions. This meant that expectations could be used strategically. One way to gain identity salience and master the expectations of others was to temporarily suspend one's own needs based on knowledge of the priorities of others. The process of 'fitting in' as described by the woman participant above was strategically managed by CHNs and midwives. The following CHN also described the process of fitting in to meet expectations when working alongside midwives:

> I guess in my role I am fairly accommodating as to what the hospital want. So I kind of fit in with them a bit, with what we need to be doing as well. (C1)

Goffman's (1967, 1983) conceptualisation of an interaction order resonates with this process and the idea that knowing the conventions and ground rules for interactions enable claims to be honoured in situations despite discrepant definitions and expectations. Yet, the point about expectations is that, as a resource, they support partnerships when negotiated. This is a fundamental pillar of working in partnership with parents advocated by the 'parent advisor' role that characterises discourses around child health practice (Davis, et al., 2002). At times, however, CHNs and midwives negotiated expectations in ways that merely gave the appearance of transparency and partnerships in care with women. Conforming to expectations meant that the positioning process could proceed relatively unchallenged as those defining the situation had greater control. Furthermore, expectations placed limits on interactions. Findings elsewhere reflect how superficial interactions result where women either conform to expectations or prevent health professionals from exploring issues (Chalmers, 1992; Jack, DiCenso, & Lohfeld, 2005) which supports Goffman's (1967) concept of a veneer of consensus. This process was described by CHNs where expectations around child protection resulted in coercive interactions to gain the compliance of women:

> But say it is not of their (a woman's) own volition that they want a home visit, it's recommended. So sometimes they are not really pleased to have to do it but I have never encountered anyone who has been hostile when I have gone, they have accepted it. (C6)

> It's good if they (women) want to see us as well, because sometimes we feel that child safety clients see us because they feel they have to. Because they are involved with child safety they are quite defensive about, trying to do the right thing often. (C3)

This meant that CHNs and midwives experienced tension between expectations related to models of professional practice, such as family partnership, and the translation of such ideals into practice. Implementing partnership in care is complex not only because of a reluctance on the part of health professionals to share power with parents, under certain conditions, but also because of the limitations imposed by organisational factors (Kruske, et al., 2006). The CHNs and midwives explained how expectations imposed upon them were unrealistic when definitions of a situation were in conflict. The following examples illustrate how expectations to monitor women around child protection were seen to conflict with professional ideals:

> ...sometimes I think child safety expectations of us is that we go in quite frequently to see the family but in our child health role we probably wouldn't need to go in as frequently because we are looking at growth and development. If we have safety concerns we notify child safety but I think sometimes the expectation is that child health is involved and they will be monitoring that family. (C3)

> Sometimes there seems to be the pressure by child safety for us to monitor clients that they are concerned about. That might be doing extra visits than we would normally do, to see clients and report back information to them. The expectation is on us and that is a difficult situation. (H1)

Participants, however, exercised some control over expectations through social processes such as positioning themselves in like groups. This is because group processes and, in particular, language has a significant function in the regulation of expectations. Through conversation people learn about their world, gain some understanding of their position in this space and thereby regulate expectations. Women were active in positioning themselves with other women for this purpose. This example demonstrates how this enabled women to compare situations and thereby regulate expectations in the SCN:

> It was really nice especially in the expressing room. All of us used to sit there and talk about what happened....Sometimes you would meet parents who had a worse situation than yours. That would give you a bit of encouragement, not encouragement, you would say "OK I am so much better off, I don't need to crib." (W4)

The CHNs and midwives similarly talked about how groups functioned to support identity salience by reinforcing some expectations and circumventing others. Interactions in like groups reaffirmed ideologies conducive to specific professional interests and reinforced boundaries. Talking in groups also allowed CHNs and midwives to resolve role conflict such as the expectations around child safety as previously mentioned:

> ...it is very frustrating because you end up feeling like you are doing all child safety's role and that is not our role, so often we would talk about that as clinicians as well. (C3)

Participants talked about other ways that expectations influenced interactions and shaped identity. There are two points here. The first concerns how people can convey certain impressions of themselves to others to preserve a desired definition of a situation (Goffman, 1973). The way that women referred to themselves as 'first-time' mothers is pertinent because this worked to modify the expectations of others and gain a temporary reprieve while mastering the maternal role. In other words, women actively invoked the first-time mother identity because it invited greater support. A further way women gained identity salience was in meeting the expectations of CHNs and midwives in socially significant ways such as providing breastmilk for their babies. Not only did this reflect desirable role performance as judged by the health professionals but also gave the women some control. Other studies have similarly indicated how women position themselves to gain control over their babies through the provision of breastmilk (Lupton & Fenwick, 2001). The negotiated process around identity through the provision of breastfeeds in the SCN was described by this woman:

> I'd ring up ahead and say "I could be here for the 9 o'clock feed and the 12 o'clock feed and I'd like to do the bath and the weigh" and they'd make sure that they'd keep the 9 o'clock feed for me if I was a bit late, like five or 10 minutes or something, but the routine would go on no matter what. (W10)

Expectations, such as the provision of breastmilk, can also become the object of regulation. For example, failure to meet expectations has a negative effect on identity where expert opinion equates 'good mothering' with breastfeeding (Knaak, 2010; Ludlow, et al., 2012) and emphasis is placed on the technical aspects of parenting practices such as infant feeding (Thompson, Kildea, Barclay, & Kruske, 2011). Expectations imposed by others without negotiation reinforces power relations that undermine partnership and choice. An inability to meet imposed expectations creates guilt that is sustained through language around risk. Guilt functions as discipline whereby those in control regulate behaviours to invoke compliance as the following woman explained:

> You feel guilty about everything. You know the breastfeeding is not working out, I have to go to formula. I was crying and crying at the thought of having to add formula to her diet because everyone was saying "Oh you know she could get cancer in her later life, she could end up a diabetic, she could end up with obesity problems because you have put her on formula and the risks associated with these sorts of things is so much higher." (W3)

The experiences around expectations demonstrated how contextual demands mediated identity. Differential capacity for negotiation around expectations and conflicting definitions of situations served to both shape the actions of participants and attribute levels of control over identity salience. The processes around expectations were significant in determining how interaction was shaped in the care continuum and contributed to the contradictory forms that collaboration assumed.

5.5 CONCLUSION

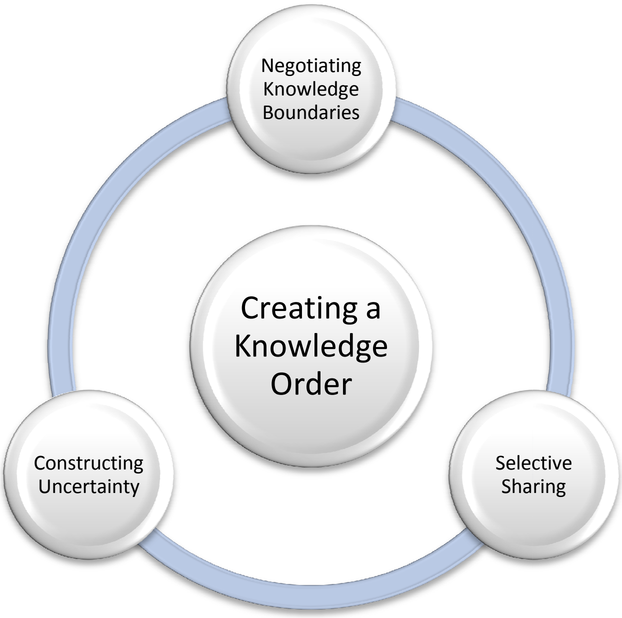
This chapter has explored the ways in which control over identity processes was differentially available to participants resulting in tensions in the care continuum where interactions took contradictory forms. The invocation of a salient identity within the research context was contingent upon the positioning of participants through roles, ownership of resources and expectations each of which was inherently precarious and yet integral to the function of the care continuum. The processes of identity-making, that is, being recognised as individuals and also as a legitimate part of the care continuum, were important aspects of the interactions that occurred between women, CHNs and midwives. These processes were mediated through power relations and conflicting definitions of situations. Hence this chapter provided insight into the ways in which collaboration (as partnership) was inserted into the research situation to conceal the complexities and allow rival individual and professional definitions to coexist. The dynamics of interactions and specifically the function of knowledge in constructing and reconstructing specific interests is the focus of the following chapter. The purpose of Chapter Six is to extend the points around complexity and ambiguity and thereby analytical insight into the research focus.

Chapter 6: Creating a Knowledge Order

6.1 INTRODUCTION

The purpose of this chapter is to explore the ways in which knowledge was constructed by participants that gave the appearance of order to the care continuum. Knowing refers to the social act of knowledge; the process by which meanings are developed, transmitted and maintained in social situations (Berger & Luckmann, 1966). In developing an understanding of collaboration this chapter explores three key processes whereby the participants dealt with the incomplete and tentative nature of knowledge. The processes reflected how knowledge was constructed and reconstructed to sustain dominant interests and therefore shape interactions in ways that attributed contradictory meanings to collaborative work. The following figure illustrates the three key knowledge processes explored in the research:

Figure 2 Creating a Knowledge Order



6.2 NEGOTIATING KNOWLEDGE BOUNDARIES

The incomplete nature of knowledge was a central factor in shaping interactions within the research context. This was because ‘knowing’ was described as a process where knowledge was shaped into different perspectives and sustained as sub-universes of meaning (Berger & Luckmann, 1966). Different interpretive frameworks constructed knowledge boundaries because they determined what elements of specific situations were significant to select groups in the care continuum. This had consequences for midwives, women and CHNs because knowledge processes were dominated by professional interests and the boundaries constructed required ongoing negotiation that shaped a large part of interaction. The central point is not that boundaries existed but rather how participants made sense of and defined situations using different conceptual machineries and then negotiated around these boundaries to create an impression of order.

Conceptual machineries are replete within professional systems and function as a mechanism whereby professionals are defined and legitimated as discrete identities as argued earlier. Ways of interpreting the world contain the recipes that are used by different groups to sustain and justify actions and to make everyday decisions. A pertinent example is where CHNs and midwives used structured frameworks to assess need and to determine what areas of women’s lives were deemed significant to professional work. The following depicts how the assessment process set in motion the identification of issues that formed the basis of, and justified, professional practice:

> Safe Start was brought out from the National Perinatal Depression Initiative so we’ve got continuity nationally, not just state by state but nationally, in the questions that these women are asked. And it encompasses alcohol use, drug use, family history, mental health family history, physical, their current mental health, they do a DV screen. The questions are set out that can help identify women with learning difficulties, being intellectually challenged and the Edinburgh diagnoses stress. So we’ve got that as well so it’s quite comprehensive. (H7)

The assessment process legitimates professional roles and sustains credibility because it assumes that professional knowledge represents a more sophisticated way of knowing. This is how professionals impose definitions on others through claims to discrete knowledge (Cast, 2003) and in this case, through the application of professional assessment frameworks. The assessment process positioned CHNs and midwives whereby an expert interpretation was more credible than the knowledge carried by the women themselves. This makes it difficult for those socialised within the professional knowledge order to see knowledge held by clients as equally valid (Mitcheson & Cowley, 2003). Pre-defined assessment processes that privilege the professional position thus challenge the notion of the client as an active participant (Cowley, Mitcheson, & Houston, 2004; Mitcheson & Cowley, 2003). What appeared as a tension between professional and personal knowledge and the process of negotiation around the exchange of information was justified in the language of teamwork as explained by this CHN:

> It's a psychosocial assessment. Really it is quite a comprehensive assessment. Then we get a bit of history from the actual mum and the red book about the actual delivery, what their family circumstances are. How we explain it to the parent is that we say we are working in a team and we normally take a bit of a history just to see how things are going for them and sometimes there might be other issues, because obviously having a new baby can be quite an exciting, challenging time but there might be some other issues going on for them. So we just do quite a comprehensive history in relation to where they are at, at the moment. And as I said we have got those three visits to do that in so we don't ask them all up front we tend to just work our way around it and use appropriate cues to get into that. (C9)

The process of bringing information to the professional domain vindicated expert involvement in the lives of the women. Yet, as Connor (1999) pointed out, unequal relationships are set up where patients are expected to disclose significant personal information that is not reciprocated. Power differentials that are constructed around the exchange of information can leave women feeling vulnerable (Jack, et al., 2005). The appropriateness of mutual information sharing vacillates between a position that emphasises professional boundaries designed to avoid exploitation in nurse/midwife and patient relationships (Nursing and Midwifery Board of Australia, 2008a, 2008b) and partnerships and mutuality in relationships with women. The assessment process reinforced the power of CHNs and midwives because knowledge gained about women and their situations ensured ongoing professional involvement.

The following excerpt acknowledges how the assessment process created demands upon the professional role:

> You are getting a lot more information that you have to act on because before, did we see everyone? Did we ask as many questions? We would never have asked about DV would we, like years ago....You just wouldn't be asking that of these women and now we have to act on these so that's more involvement, a lot more, in the midwifery model. (H6)

The assessment functioned to define obstetric and child health risks and to stream women into levels of services. The categorisation of patients using psychosocial and biomedical risk factors reduces unpredictability around patients giving the impression of smooth and successful management (Armstrong, 1987; Prior, 2009). Women were socialised to this process and accepted the categorisations assigned. This woman indicated how this process also framed choices:

> ...they take a full history about your parents and yourself and your partner and everything and then they classify you as low risk, high risk or medium risk pregnant woman. I was low risk pregnant so they said, because they keep the spots at the hospital for more high risk pregnant women, I had either a choice of continuing to see my GP and see the midwife once in a while or they would put me through (clinic). (W4)

The act of assessment rested on a premise of consistent practice among professionals as indicated above in reference to the continuity of questioning in national frameworks. This claim is reflected in professional and policy documents that advocate common assessment processes (Australian Health Ministers' Advisory Council, 2011; Australian Health Ministers' Conference, 2011; Australian Research Alliance for Children and Youth, 2010; New South Wales Department of Health, 2009). By contrast, the assessments in the research context were open to interpretation, because midwifery and child health assessment frameworks differed and the conceptual machineries were subject to individual and social influences. This CHN explains how definitions of situations were influenced in a variety of ways as different personal, social and professional experiences were brought to the assessment process:

> I think a lot of the picture (CHNs have) is from past experiences themselves with other clients, maybe...So a lot of it's from pre-learning, from education,

> some from past experiences with other scenarios, clients. They're bringing things with them they have got ideas of, maybe even their own experiences. I mean it's not just around family violence it's other things too, and their values, what they bring with them in their values and things like that....The word family violence and domestic violence it's in the papers, it's on TV, the risks around DV. (C5)

Assessment knowledge was constructed in a form removed from the contextual realities of individual women and so select aspects of women's lives were defined in a way that disputed the notion of holistic care. In addition, when this knowledge was transferred throughout the care continuum this meant that who knew what became more and more obscure. Midwives and CHNs appeared aware of the limitations of the fragmented nature of the knowledge process. For example, when information was transferred between CHNs and midwives, such as through the referral process, the possibility of knowledge gaps and different interpretations had to be taken into account as indicated by this CHN:

> It is always very different when I see them. I don't know why it is. There are so many times when a referral looks very innocuous and when you get to the home it is a completely different story and vice versa. (C4)

Storylines were a less elaborate, more informal process that CHNs and midwives applied in ordering knowledge and functioned much like typifications around roles and identity. Storylines are social dialogues that develop around people as types that become methods for making sense of other similar or different people and situations. In other words, they are conversational phenomena that assign individuals to 'parts' or roles in social situations, essentially positioning them (Davies & Harre, 1990; van Langenhove & Harre, 1999). The CHNs and midwives engaged storylines to consider possibilities and to predict how others may act in planning their respective actions. This CHN explained how storylines were useful in predicting resistance of women to home visits:

> ...those clients are the ones that are more likely to not answer their phone or the phone has been disconnected because they have either lost it or sold it or not paid their phone bill, so they are the ones that are really hard to engage with....So they're the ones that have lost trust in people, they are less likely to be open to our visit... (C5)

Knowledge processes were covertly played out by CHNs and midwives where assessment information was shaped and reshaped as it was transferred between groups and clinical settings. While receiving information prior to seeing women allowed for the planning and organisation of care, CHNs were aware of how information had been shaped by the professional process and by previous informants. This meant that knowledge had to be tested out. CHNs framed the negotiation of knowledge with women as ‘relationship building’. The following exemplifies this process:

> Because am I getting the referees perception of what’s happening. I would like to be able to think. OK, an open book, you are a new client I know I have got this information but I need to build up our relationship and find out what I need to do for you without any clouding. (C1)

As indicated, the assessment process attributed an order to knowledge while simultaneously compartmentalising knowledge. Midwives and CHNs would interpret information and form perspectives that were relevant to their professional role. The result was a perception that women conveyed different ‘stories’ to different staff while women had the impression of being asked different things by different health professionals. The CHNs and midwives were alert to different perspectives and stories and developed professional processes to compare what each other knew and therefore to obtain a more complete picture. For example, health professionals would come together in case conferences or group meetings or work behind the scenes to inform each other thereby gaining greater control. The assumption was that shared knowledge was more powerful, a situation not achievable by working alone as indicated here:

> ...they just see people on that one-to-one basis and that’s why that case discussion is so important. Because very often they will tell the social worker a very full and frank and different story than you have heard, from the bit you have heard as the midwife. So they do sort of relate quite different things about themselves to each of those different disciplines so that’s why it is so important that we get a bit more of a comprehensive idea of what is going on for this woman from each of the disciplines point of view. You certainly can’t do it as one person. (H4)

Furthermore, the need for negotiation increased when it was perceived that knowledge was incomplete such as where women were involved with a number of professionals. Different types of knowledge bring a range of alternatives to a situation; what Warshay called a “breadth of perspective” (1962, p. 149). So rather than providing alternative definitions that construct boundaries and challenge an overall knowledge order; perspectives can prove useful to bring about shared understanding. Nonetheless, where the woman’s perspective in the knowledge sharing process is less salient this contests the notion of transparency and sustains the privileged position of professional knowledge. The following example indicates how sharing perspectives about women is justified as teamwork while the absence of women in this process reinforces the hierarchy of knowledge led by professionals:

> ...with our team meetings you do hear about the clients from other people’s perspectives and that is very valuable.... Makes you feel like you are working as a team. (C2)

Perspectives provide an indication of what others take for granted in the definition of situations and become points of departure or convergence when aligning actions to achieve certain goals. There is also a potential for conflict to occur if joint action is not achieved. In this situation, perspectives function symbolically to justify actions where a view is limited in its influence on others. The following indicates how responsibility can be abrogated on the basis of perspective taking:

> They (child health) do see it differently and...I can spend quite some time doing an enormous referral and then at the next meeting I’ll get “Oh yeah we couldn’t contact her so we have just sent them a pack.”....I don’t like it but it’s not my call. As long as I have done my bit and I have followed them through I am happy with that. I just can’t do the rest as well. (H5)

A related process underlying perspectives and assessment and contributing to knowledge boundaries were relevances. Schutz (in Wagner, 1970), explained how systems of relevance function where individuals ascribe importance to aspects of specific situations and use them as interpretive or orientating schemes. Some relevance systems are dependent upon personal priorities while others are imposed (Schutz in Wagner, 1970). Organisationally imposed relevance systems included guidelines and criteria that dictated what knowledge was important and how it functioned to make the care continuum work. Where relevances such as intake criteria and what constituted complexity in care were fixed this was a controlling factor in interactions. On the other hand, knowing something about what may be relevant and less relevant within interpretive schemes meant that information could be reconstructed to shape the actions of others such as in the referral process between services. Midwives needed to understand the relevance systems of child health services to have referrals accepted and acted upon even though opinions about what constituted complexity differed. The following reflect the contradictions and how differences were negotiated:

> ...how I identify them or what I say is a complex lady, is basically anyone on the baby referral that ticks a box up there and that is how I identify them, that's my criteria. So I just stick to the criteria to identity them, but I think anybody really is complex. (H3)

> We have the referral form and all the details that they're interested in are on there....Because we know child health has social workers and they have therapists and they have groups and the sort of things that they would want to be concerned with....So we aim towards their services. (H10)

Relevances were also used coercively to influence others, for example, where CHNs and midwives worked hard to gain control of situations by selecting and communicating specific information to women. The following illustrates how more coercive negotiations shaped information sharing where women were deemed at risk:

> ...just going to see the at risk clients we are making sure those ladies have that information so we actually don't give them a choice, where the other ladies probably have a choice, as to whether they want to know any more about child health they would probably have a choice, whereas we actually physically walk in there and say "Hi we are here, we are one of the midwives, we are here to tell you about what happens when you go home." So it's in their face and they have to hear it. I mean they could tell us to go away but nobody ever says. (H3)

There were mixed views on the position of women as equal players in the knowledge process. At different times women were referred to as experts which suggested a privileged position although context and experience defined the space in which women could be experts. For example, women in the SCN and first-time mothers found it more difficult to be seen as experts and partners in care. This position changed when women left the hospital as this woman explained:

> It's much easier to tell in the community what you want and take your stand than in the nursery because you're learning and they are the driver there, here you are the driver. (W4)

Apportioning of expert status is a fundamental principle of frameworks such as the 'partnership model' that is promoted as a preferred way to work with parents (Davis, et al., 2002). The partnership approach argues that the assumption of professional knowledge as superior should be substituted by a more collaborative model that acknowledges the expertise of those being helped (Davis, et al., 2002). A process of interaction appeared in the research whereby women were invited to share a perspective because this process would narrow the knowledge gap. The intent was not always to shift control to women but rather to give the impression that collaboration was occurring by representing women as experts. Midwives and CHNs still perceived themselves as best equipped to identify what was significant in terms of knowledge. The following illustrates how impressions are managed around the expert role and the translation of knowledge:

> So my most important thing on that first contact is saying who I am, introducing myself and saying where I have received the referral from and that I have some information. I might even say "they send us the referral form to say baby was in special care so I have a little bit of information about it. You know your baby was born this week." You know and then give the impression that they're the expert and try to seek information from them and so I think it just sort of demedicalises it a bit. (C7)

Creating an impression of shifting the expert role implies a transparency that was not manifest in the research. Transparency implies that the women understood the ways in which CHNs and midwives sought to share (or not share) control. The actions of CHNs and midwives, however, were more akin to covert justification of the professional role. Indeed, the suggestion that women were 'allowed' to be involved meant health professionals had the ultimate control. This position is exemplified in the following:

> ...before we used to be the expert and the dictator and would say you need to do this, this and this, but now by being transparent it's allowing the clients to be involved in their own care...they tend to have a better understanding of what we think is happening for them and it means we are wanting to listen to

> what their needs are. That's probably where I come from with transparency. (C5)

In support of the above, the CHNs and midwives pointed to preferred sources of information that reinforced professional knowledge as more valid. This meant that any appeal to personal experience or knowledge was perceived as deviant even though people were conceived as architects of their own destiny. The contradictions in the following reveal first, how professional knowledge was privileged because it was considered 'pure' and free of bias, and how, on the other hand, women saw that professional advice was influenced in certain ways:

> I like the idea of government health being a primary source of care for families because they don't have a vested interest. I love the idea that women can go to a clinic at a shopping centre or something like that, but the thing is it's not entirely a selfless venture is it because they're in chemist shops and they're encouraged to buy things before you come out, and are they getting the right sort of information? Would the midwives who work in there be pressured perhaps to sell things? Whereas I feel that the government has nothing to gain but the health and wellbeing of its citizens, and for that reason I would really love to see child health emerge as a leader in offering the postnatal care because it's altruistic and pure and also good information, untainted. (H10)

> Some midwives are really pro breastfeeding, and I think some other midwives probably would have been more I guess, "it's fine using formula." I think Queensland Health itself, I think they promote breastfeeding quite strongly. I think that's influenced the staff members there. Because you're working in the government. I work for government myself so you don't do stuff that's not in line with your government's sort of thing. (W9)

Women realised that professional knowledge was incomplete and vulnerable to personal interpretations. This opened up the opportunity for women to pose personal opinions through individual negotiation. The paradox was that women were socialised to professional control of knowledge which positioned them passively at times while in control at other times. This woman explains how the process of filtering information operated to mediate knowledge:

> And it was true, you would get a lot of conflicting opinions. So take from it what you can and leave behind, filter out, because with the changeover of staff I suppose, especially as a first time mother you'd have one nurse tell you to do one thing one way and then the changeover of staff and they'd say the complete opposite....Because there were so many conflicting opinions I think it just suddenly dawned on you "just do the right thing for your babies, what you think is right." So you filter out the information you're getting and take the best from it of what you can. (W6)

Communication with the same CHNs and midwives was a means whereby women could reduce exposure to conflicting information. There are limits on this because, as reported elsewhere, women receive inconsistent advice in the postnatal period despite continuity of care (Homer, Davis, Cooke, & Barclay, 2002). Continuity, however, increased the chances for the women to establish a shared storyline that was built and retained over time. This meant that previous knowledge was implicit in ongoing interaction as these women indicated:

> ...the consistency with having (CHN) helped because I didn't have to retell my story every time. She could walk in the door, she knew me, she'd find out where I was at and how things were going and yes, I know there are notes but it really made a huge difference. (W10)

> I had the same midwife with (baby) for four or five days which was nice because you'd go there each day and you'd be able to follow-up with what happened yesterday as to what happened today. Whereas I know you can still do that if it's a different midwife but it's just, I don't know, it was nice speaking to the same person and I guess you build a little bit of rapport with them as well. (W7)

Continuity was also useful for the CHNs and midwives but in different ways. An example was how CHNs and midwives would store professionally relevant knowledge to be used strategically through everyday conversation and to follow up on specific concerns with the women. Appleton and Cowley (2008) found that health visitors used knowledge in this way, because they carried around a lot of undocumented information about families in their heads. Continuity in care relationships therefore fulfils a function of being able to engage knowledge that has been 'stored' as relevant at strategic times to fit particular purposes and as a catalyst for structuring conversations around relevant professional concerns. This CHN explained this process:

> ...it's about continuity and a client not having to tell the story again and again and the nurse to be able to go "actually she said something about that a few weeks ago, I am going to jump on that this time." or I've thought about it and if it goes this way I am going to guide the conversation. You have a lot of stuff in the back of your head that you are guiding the conversation. (C8)

While negotiating knowledge boundaries formed an ongoing part of the interaction between CHNs, midwives and women other factors were also important in the construction of an order to knowledge. One such factor was how dominant definitions of situations constructed and sustained uncertainties that had consequences for interactions.

6.3 CONSTRUCTING UNCERTAINTY

Uncertainty existed because not all participants shared equally in knowledge processes. In the previous section it was argued that professionals sustain control over situations through the primacy given to professional knowledge. Yet the assessment process structured information in ways that also gave rise to uncertainty because the medicalisation of knowledge opened up a greater array of potential concerns and risks. The process of knowledge constructed by CHNs and midwives perpetuated uncertainty because knowledge, whether incomplete or abundant, was inherently problematic. There were always factors that were unpredictable as the following midwife explained:

> You know it is so subjective I think how women are going to act and react to their children. There is nothing universal about it. Women react in such a variety of ways to birth that it would be hard to make any of that a universal thing. (H1)

While some uncertainty is exciting, making us feel edgy and alive, for the most part people find it aversive (Hogg, 2005; Penrod, 2007). Dewey and Bentley argue that people can and do accept some vagueness in their work (1949). In fact Blumer pointed out that there were "possibilities of uncertainty" (1966, p. 541) because of the highly variable aspect of human thought and interaction. The point is that, although knowledge can be shaped to give the impression of order it always remains in a tentative state because of this variety. Yet uncertainty is often framed as a non-normative state that existentially subverts the social processes required to mediate this (Penrod, 2007). An emphasis on objective ways of knowing embedded in professional knowledge processes does not sit comfortably with ‘knowing’ as an emergent situation where control is gained in the process. At times uncertainty was conceived as a useful staring point in the knowledge process. This meant adopting a not-knowing stance, a process whereby professionals shift from the position of expert knower to a more tentative and collaborative position working *with* rather than *for* families (Anderson, 1990; Hoskins, 2011). The following excerpts indicate how limited knowledge can become a starting point for ongoing work:

> We probably get a bare minimum of information but I really don’t know that by having any more that is going to help us. (C10)

> We have a look at it (the referral) and you go, yes there was a problem with the birth or it was a prem or it was this or it was that and you can actually see very quickly at a glance these are what my things are going to be. But I think the most important thing is once you go (you see that) it’s not so much about what’s on the referral, it’s what you actually see when you get out there. (C10)

There were, however, two positions on this. As argued, where uncertainty was framed as a relatively normal part of the knowledge process this provided CHNs and midwives with the motivation to seek other information and to use a full range of options to do so such as communicating directly with women. The second was where uncertainty was problematic because it implied something unknown and therefore risky. In this situation, unilateral professional action was taken to limit uncertainty. The following exemplars illustrate how CHNs adopted divergent positions on uncertainty:

> ...you might get a referral that hasn’t got much on it and then you walk into the house and you start getting the history a lot more comes out so it works both ways I guess. So the referrals can be really frustrating. But I think they are the best, you know, that is what we have got and that is what we work with. And we have to run with that a bit as clinicians. (C3)

> Sometimes we do have to ring up and get more info just to make sure it's safe to visit and just to nut out and see if there are any other things we need to be concerned about. (C6)

Enduring concerns associated with uncertainty justified ongoing professional involvement in the care of women and their babies. Midwives and CHNs were alert to uncertainty as segues into information exchange and hence a place for the professional role. The following is an example of how uncertainty became an impetus for information exchange:

> In the visit we make sure that the women are aware of how next to proceed because sometimes there's that period of uncertainty, so we ask them about their plans, what they intend to do as follow up and suggest, if they haven't got any, that these facilities are available. So we would talk about the routine to the GP for example for health checks. We would talk about the facilities from their local child health looking at classes that are available and support, facilities for checking the progress of the newborn. We also look for after hours support for them so that they don't feel abandoned or alone, if they're worried. (H10)

For CHNs and midwives uncertainties legitimate ongoing involvement with women which shifts the relationship away from partnership to knowledge dependency. An alternative argument is that the amount of health information available to women in the public domain mediates uncertainty and therefore dependency on health professionals for their discrete knowledge. On the contrary, Fournier (2000) argues that diffusion of professional knowledge into the public domain increases the chance of people defining their problems in professional terms. This opens people's lives to further professional scrutiny and engenders a stronger reliance on professional authority by cultivating anxiety, uncertainty and complexity (Fournier, 2000). For example, first-time mothers become anxious when burdened by large amounts of information (Carolan, 2007; Craig & Dietsch, 2010). The women participants indicated that too much information was a burden. Indeed, the knowledge-burdened woman was one who required professional intervention in order to extricate legitimate from illegitimate knowledge. The following exemplars from two first-time mothers demonstrate first, the uncertainty of information, and second, how this shaped dependent relationships whereby professionals were called upon to confirm that women were on the right course:

> Because you are tired, you don’t know what you are doing, confused, you have got all this information in your head, you think you are going to kill your baby... (W2)

> Because you don't really know if you're doing anything right or if (baby) is OK....Nothing is finalised until the professionals see. (W5)

In general, professional credibility elevates a professional definition of a situation where uncertainty and risks predominate and sustains the professional position. Yet, even when risks are limited, professionals can create risk and uncertainty, for example, by surveillance of pregnancy and birth which constructs ordinary life events as risky (Lothian, 2012). Furthermore, the delivery of ‘medical-type’ information can overwhelm and create fears among first-time mothers (Carolan, 2007).

Other studies have refuted the above assertion demonstrating how women acquire skills in discerning information over time and establishing maternal ‘know how’ (Rowe & Barnes, 2006). Women and other family caregivers gain a sense of control and confidence through coaching and encouragement that goes beyond knowledge sharing (Rowe & Barnes, 2006; Rowe, et al., 2013). Studies have also demonstrated that the provision of information to women is not enough to reduce uncertainty and foster self-efficacy in, for example, gaining confidence to breastfeed babies (Craig & Dietsch, 2010). Rather, uncertainty results as a product of the imperative to ‘do things right’ (Craig & Dietsch, 2010). The imperative to do things right further sustains the professional role as the following woman explained:

> ...because a first time mother I think you really rely on the help in the nursery, you’re still going through that "am I doing the right thing, am I doing the right thing?" so the older midwives and nurses were just amazing, I found in the nursery. They were so wise and relaxed, because this is their job and they see it every day but for you, I think you’re so wired up and emotional it’s good to have that level headed person. (W6)

There were, however, opportunities for the women participants to develop levels of control over knowledge. An example was discharge from hospital which meant that women could be more prominent in managing uncertainty. The position of health professionals as the final authority changed as women gained control over the knowledge process. It is known that women mediate uncertainty and establish the ‘right ways’ of infant care through advice from friends, family and multi-media (Gildea, et al., 2009; Heinig, et al., 2009). The following indicates how resolving uncertainty was significant to women and shifted with experience:

> The thing is, when I was in the nursery it’s still new to you, so you yourself don’t know what’s happening so you tend to follow what somebody advises you like because you don’t know. So how will you know whether you’re doing right? When somebody says its right is only when you confirm it’s right. But now it’s been three weeks that she’s home with me, each day I try to learn. And now I know "okay if she’s crying she may be hungry" so you yourself know through experience that it’s right. So there you needed them to tell you it is right, now it’s me who tells it is right to them. (W4)

Schutz (in Wagner, 1970), suggested that selective attention operates because things are often overlooked until problems occur that prompt the need to know. This is because pragmatic concerns and contextual uncertainty are prime motivators for knowing. To cope with the plethora of information people order knowledge and so relevance depends on immediate needs. The professional knowledge order challenges this by constructing different relevance structures based on a dominant professional definition of the situation. Midwives and CHNs perceived that a large part of their role was providing information to women that would prevent problems in the future and thereby limit uncertainty. This view positions people as either ‘knowers’ or ‘non-knowers’ and is based on the power of professionals to define what is significant knowledge in a situation and where this applies. The provision of information to women during the antenatal period reflected an objective view on the knowledge process that did not match relevance systems. The divergent views on information relevance were summed up, first by a midwife and then a woman:

> They have got information because they have done the childbirth class and they have done a parenting class, and they have done a breastfeeding class so it’s given them the education to take on board now to help them look after a baby. (H8)

> We spent nine months preparing for labour and didn’t prepare for anything after. Like we never read about sleeping, we never read about feeding. I just read the same labour books over and over. I suppose you get focused on labour. (W1)

Responsibility for knowing, defining relevances and managing uncertainty rested predominantly with health professionals. This meant that information was reinforced time and again. While women found this situation confusing, CHNs and midwives considered it a necessary condition of the knowledge process. Two exemplars reveal the divergent positions on this:

> Because women need to hear that again and again, like before they leave hospital, even if we are ringing, making appointments I think how horrible it would be going home yourself and not knowing anything. (C6)

> I found it really draining in a sense when you would continually go over things, rehash or fill in forms that you have filled in before. I found that weird. (W2)

The point is that receiving information may not be meaningful for people and may not resolve uncertainty because it is neither timely, nor can it cover all possibilities. Tolerance for ambiguity varied and assumptions about the knowledge order constructed more uncertainty than was resolved. Furthermore, the highly differentiated division of labour contributed to uncertainty as the fragmentation of knowledge occurred. This was because information was collected and knowledge built progressively throughout the care of women. What appeared as an overall order consisted of different levels of uncertainty as different sources of information. Processes were developed to overcome this fragmentation as this participant explained:

> ...we end up with notes all over the place. So (department) do their thing in their set of notes and the (service) do their things in their set of notes and mine, it drives me insane. Once a woman delivers you have to tell the receptionist "can you put these notes with these notes please." (H7)

Midwives moving between different clinical areas in the hospital were alert to this fragmentation and able to capture random information, including that which was not recorded in medical records. To do this, midwives positioned themselves strategically to gather information in consort with others. The following provide examples of how key people worked together to gather information informally:

> We have a big input from the midwives who go around and they will see these clients on the ward and then they will feed back to me who is around.

> So say Mary is upstairs and she is going to be discharged and they will just, so that I am aware of what is going on, they will give me a bit more information than what may be printed on the referral forms. (H6)

> Informal things would happen every day. Just some little tit bit, “oh did you hear about”, and you go “yep I know about her but that’s really good that you told me that about her.” So you have got her maybe on your radar to see but they have filled you in on a little bit more to the story. (H3)

A further way in which uncertainty was constructed and maintained was through communication of inconsistent information as highlighted in the previous section. This form of information exchange exacerbated uncertainty, increased the dependency of women and undermined confidence and self-efficacy. This has been reported by women in similar contexts (Dane, Thompson, & Miller, 2011; Fenwick, Butt, Dhaliwal, Hauck, & Schmied, 2010; Homer, et al., 2002) and attributed to the busyness of postnatal environments where the time midwives have to meet individual needs is limited (Fenwick, et al., 2010). The following indicated how uncertainty was sustained by individual differences in information provided by CHNs and midwives:

> And everyone was different, everyone had different techniques with breastfeeding...everyone had different preferences on how you breastfed. It was not one straight down the line this is how you do it. It was kind of like “well I like doing it this way.” And then you would start doing it that way and then the next person would come on shift and it would be “oh no don’t do it like that do it this way.” (W2)

While uncertainty around some information was deemed acceptable by CHNs and midwives other information required greater certainty because the consequences involved personal safety. An example was the scheduling of home visits where there may have been risks. So although CHNs and midwives were socialised to the incomplete nature of knowledge some uncertainties were more significant than others and required sustained hyper-vigilance. The following dialogue demonstrates how the dimensions of uncertainty influenced information exchange between midwives and CHNs around specific concerns:

> From my point of view I think they (child health) just want to know as much information that they can so they can be forewarned before they go in. I especially see this with family violence...if it says DV well is the ex-partner

> living there, does he not live there, is he going to be there, should it be a double visit, should they not go at all, should they get them to come in to the community clinic? (H3)

Uncertainty was reinforced when information was gained incidentally despite all the processes that were set up to order knowledge. The ongoing vigilance for errors and omissions meant participants positioned themselves strategically to capture information and a range of processes were set up to further manage information. The anxious environment of child protection is an example of how checking and rechecking is legitimated and sustained as a defence system even though it contravenes collaboration and partnerships (Menzies, 1960; Morrison, 1996). Midwives and CHNs described cross checking and collating information for which others were responsible, particularly at specific points in the care continuum such as when women and babies were discharged from hospital. Thus processes came to depend on people in certain roles and in certain places to connect information and limit uncertainty:

> And that is where the discharge facilitator (is good) if she has stumbled across anything, because what happens with those referrals because they are filled out at the beginning of their pregnancy. If the course of their pregnancy has changed...(if) they have had a medical complex problem or its come to light that they have got a drug and alcohol problem or something like that, we would not know. And they probably have not updated those forms, they are not updated, and so that is where the discharge facilitator has that input and writes stuff on the referrals... (H6)

Women also positioned themselves to limit uncertainty such as finding ways to be present at strategic times such as at staff handovers and clinical rounds in the SCN which enabled them to access the information that health professionals had. This also allowed women to gain legitimacy in situations that may have otherwise been off limits. The passive act of being informed shifted to active information seeking as this woman indicated:

> ...I would chase the nurse, “Did her blood results come? What is this like?” etcetera....He used to talk with the doctors even if they were not on rounds. If he found them anywhere he would catch them and ask them “What’s happening?” (W4)

> If you are doing something with your baby (during rounds) you can stay. If you have just come in and you are not doing anything you need to go out. It’s actually confidential because they discuss about the other babies as well but if you’re feeding your baby or changing the nappy they won’t tell you to go out....One mother told me that they won’t send you out if you’re feeding your baby and things like that so I tried to time myself. (W4)

Although uncertainty shaped a significant part of the knowledge process that underpinned interaction between participants other factors such as the selective sharing of information also influenced the knowledge order. The following section explores this process.

6.4 SELECTIVE SHARING

As noted above, knowing is socially defined and social distribution is part of the general stock of knowledge in any society (Berger & Luckmann, 1966). People understand knowledge as socially distributed as they become aware of the limits of their own and others’ knowledge. In addition, people sustain this process because they do not share their knowledge equally, in fact people may choose to withhold information about themselves as a means to maintain control and to resist imposed identities (Cast, 2003). There was acknowledgment of the selective sharing of information during interactions between women, CHNs and midwives. Indeed other studies have found that women withhold information from midwives when other family members are present during assessment or when information concerned substance use or child protection (Phillips, et al., 2007). At other times women actively withhold information to avert professional scrutiny or avoid feelings of discomfort when asked to recall traumatic events (Rollans, Schmied, Kemp, & Meade, 2013). Women have also reported being unprepared for the disclosure of personal information during assessments, preferring greater control over this process (Rollans, et al., 2013). The following exemplars drew attention to how all participant groups acknowledged selective sharing of information existed:

> It's like when you meet someone for the first time...you're not going to tell them your life story first up, most of the time, unless you feel really comfortable with them. (W7)

> I know some people are a bit wary of what information to give you. (C9)

> It’s up to the women to disclose what they want you to know and what they want help with. (H3)

In sharing information selectively the participants actively maintained the social distribution of knowledge. Sometimes this reflected the different ways in which knowledge was compartmentalised. At other times selective sharing was a mechanism by which control was assured, for example when over-communicating some facts, under-communicating others or choosing not to communicate at all. Participants received explicit and implicit messages about what needed to be brought into the open because information would also affect the impression others formed. Goffman (1967), highlighted how people managed the impressions that others held about them because first impressions were important in interactions. Where information about women was gained by CHNs and midwives prior to consultations this had the ability to influence first impressions. Conversely, by withholding information women can exert some control over how situations unfold (Jack, et al., 2005; Phillips, et al., 2007; Rollans, et al., 2013; Wilson, 2001). Sharing information selectively was a means to avoid or challenge the typificatory schemes of others, to avoid being seen to deviate from some socially established norms and to avoid scrutiny (Ludlow, et al., 2012). Further, in influencing who knows what, preferred definitions of situations are reproduced. Women received implicit messages about what was acceptable to share with CHNs and midwives as suggested here:

> If I tell the lactation (consultant) I’m pumping it out and giving it through a bottle she might not be happy about it but that’s what works for us so I’m happy to stick with it. (W4)

> No one wanted to hear that I was going to give him a bottle every now and then....I felt like I was doing the completely wrong thing by giving him you know formula or a bottle if he was hungry and I didn’t have enough to give him from myself. (W2)

Women, midwives and CHNs accepted a certain amount of selective sharing of information as part of the way things were, that is, as socially distributed knowledge. This served to maintain interaction while creating conditions where information exchange could proceed. Women would avoid the risk of being judged as incompetent mothers by exercising caution in sharing information as noted above.

The association of good mothering with breastfeeding and poor mothering with formula feeding encourages women to selectively share information (Knaak, 2010; Ludlow, et al., 2012). Hence the knowledge order is underpinned by information that is always potentially incomplete, highly contingent upon information sharing and reflective of broader social influences.

Yet control over information sharing processes existed differentially in the system. For example, where CHNs and midwives defined situations in professional terms, such as safety concerns around home visiting, processes were set up to manage suspicions around selective sharing of information. Parents did not need to know about the assessment process and so this form of information was not considered as part of any commitment to transparency. Other studies, however, have concluded that women glean implicit messages about what is being assessed and why (Cowley, et al., 2004). Women were aware of how information obtained from them was being used by CHNs and midwives despite this not being openly discussed, as the following demonstrates:

> And each time they visit they always ring to make sure that it's safe to come to the house and ask me questions. "Is anyone home"? "Is anyone else home, any pets, anyone sick?" It's more to protect themselves and things like that. (W5)

Other information selectively shared includes that around suspected child abuse or neglect as notified to child safety services. This process does not always require parents to be informed (Queensland Health, 2011). The CHNs and midwives considered that their own safety relied on the withholding of information from parents and so information was shared between health professionals in separate processes. The following indicates how processes were developed to support selective information sharing for select types of information:

> ...for whatever reason the parents might not be aware that a report has gone in. Sometimes that might be a safety thing. So sometimes there will be information about that they might put it on another sheet, that might work that way but that won't be shared. (C7)

Hence, decisions are made about what knowledge is shared with whom and when, and thus the parameters of the knowledge process. There are also limits imposed on knowledge sharing by contextual factors including competing priorities for information and time. Midwives and CHNs often had to deliver information to women based on pre-defined relevances and within time constraints. Various tools including information sheets and pathways exemplified the priority system. Other processes were developed to manage knowledge priorities such as categorising women into groups as ‘at risk’ women and ‘first-time’ mothers. Where ‘at risk’ women were defined in need of special information the assumption was that this would reduce risk. On the other hand, first-time mothers were categorised as ‘non-knowers’ and therefore in need of being informed about things as a matter of priority. While ‘at risk’ women and ‘first-time’ mothers were two groups with different vulnerabilities this categorisation process reflected how priorities were constructed because not everyone could be informed due to time constraints. Yet, limited time and ‘tick box’ approaches to care can result in information being provided prescriptively or in a ‘black and white’ way (Fenwick, et al., 2010). The following indicates how time constraints in the postnatal period place limits on information sharing:

> But a lot of the time if they are not at risk women or they are multies the staff will just say “is there anything on the sheet?” Because of time restraints, “is there anything on the sheet that you want to know? Tick anything that you already know and we will go through anything else.” (H3)

A similar occurrence in the selective sharing of information was where CHNs and midwives made decisions about what would be shared with women and what withheld, justified as protecting women and limiting their distress. An example was in the SCN as the following midwife explained:

> In the acute phase you’re just making sure that the parents aren’t being sidelined. You’re encouraging them to be included in everything that’s happening to their baby, and it can be difficult because with procedures, it’s distressing for them and so forth but they have a right to know when it’s happening. Like an example, it’s the middle of the night and a little one has taken a turn for the worse and they’re going to pull in a chest x-ray and staff will debate about whether they should wake the mother to let her know. (H10)

A situation of selective sharing such as this perpetuated mistrust as participants became aware that information was being selectively filtered. Women perceived that certain information would be shared with them only when things went wrong. This in turn created a desire to retrieve information as women became more curious about what was hidden. The following provides an example of how details would come to light for women incidentally:

> ...there's a kind of a void of information when you're there (SCN) because you only hear about things that are wrong. Like she had scans and tests and so on and they just mentioned them in passing "oh yeah, she had blah, blah, blah", it was like “really.” “Oh the cardiologist came and saw her and we found a mild heart murmur.” I go “really, there’s a cardiologist seeing her?” “Oh yeah, all the babies are checked.” I mean there is an information book but, and the other mums complained about this, they say “Oh you don't know what's going on.” But unless you asked you could just go in each day, do the cares for the baby and go home but you didn't know that there were all these other things going on and it wasn't until something went wrong, if something came up that was of concern that you'd actually hear about that test. (W10)

The professional system of decision-making was a largely unilateral process. Everyday issues were perceived as unproblematic, to be dealt with using clinical and professional judgement. This allowed decisions to be made with a minimum of fuss because what was defined as ‘routine’ did not need to be shared. The CHNs and midwives thereby engaged in a selective sharing process. The rules changed when problems were encountered or events were defined other than routine. The following CHN described how information sharing was required under certain conditions:

> If they (CHNs) have any concerns around that home visit or that centre visit they will come and see me (manager) and have a discussion about it but if they are not concerned I don’t hear about it. And so I rely on them to use their professional judgment on whether they need to have a discussion around that client. (C5)

Selective sharing of information was also justified where intentions were questioned, for example, when suspicions existed about how others might misinterpret and use information incorrectly. At times this was dictated by previous negative experiences around information sharing where interpretations made by other health professionals were based on different frameworks of understanding. This went on to govern what was shared with whom, the specific language used and the sanctioning of information to protect women as indicated here:

> I have also learnt to be careful what I write because I have learnt that their knowledge base on (health issue) is not great for all of them. They will read word for word without understanding the full context or impact of what they are saying to the woman. So for instance we may have diagnosed someone as having a disorder. That may not have been discussed with the person we may have put that in different terms. (H7)

The selective sharing process was more difficult when participants were positioned outside the rules and conventions of information sharing in particular contexts. Without this understanding and with limited participation and limited resources to challenge the status quo, selective sharing perpetuated unease. This was perhaps more so for women who were less powerful and in less control. One woman explained how this process ensued in the SCN:

> Because you are really scared in there because you don't know whether it's OK to ask questions... (W2)

Women understood that professionals knew best and placed trust in them to do what was needed. This process justified and sustained professional control of knowledge and maintained the partial participation of women in the knowledge process. As Corlett and Twycross (2006) argue, nurses manage participation through control over the amount of information they pass on to parents. Attempts at participation did not always procure the answers that women needed because health professionals had the legitimate authority to maintain the status quo. There were, however, limits on professional control. In the following situation the selective sharing of information was challenged and this woman was able to assert her right to information in the SCN which changed participation:

> Because it's daunting, all these monitors are attached to her, and there's beeping screens and alarms going all the time and you are like, "what's going on?" and they were really good about it whereas previously I hadn't found that. When I said "oh what does that mean?" and (they said) "Oh look don't worry about it we know what we are doing, we are monitoring, she's OK." (W3)

Selective sharing of information was also influenced by other factors such as the consent process. This concerned who had the right to know what and the rules about who could share what information with whom. Some information sharing was in the hands of professionals such as in the mandated processes around protection of children. In other cases it was women who assumed control by asking that information about themselves not be shared with others. Midwives worked hard to gain the consent of women to share information with CHNs but realised the limitations on this and where women needed to assume this role:

> I used to do letters all the time. If I recommended it I would send off a referral anyway, but then consent changed with child health and you had to actually obtain the consent of the mother to make a referral. (H10)

While CHNs and midwives perceived that women concealed information of their own accord, women also involved CHNs and midwives in mediating decisions to share information. Similar findings have been reported around sensitive information disclosed to CHNs demonstrating how information sharing is openly negotiated with women or sometimes hidden (Rollans, et al., 2013). The following reflects how women sometimes took an active part in selective sharing of information involving health professionals in the process:

> The women see me writing in the notes so I have had occasions where maybe they are disclosing something and they'll say "I don't want you to put that in the notes." And I'll say "That's fine." (H7)

When CHNs received information from hospitals there were conflicting messages about how women had been involved. Other studies suggest that, in the large part, women are not involved in information sharing during discharge from maternity care (Jenkinson, et al., 2013). Glaser and Strauss (1964) argued how awareness contexts influence interactions because of selective sharing of information. There are two relevant points here. First, transparency in information sharing was deemed important for working in partnership with families because trust relied on shared knowledge. Second, information that was selectively shared or filtered in some way required further work to reconcile meaning and maintain the impression of partnerships. Chalmers (1992) argued that concealed information affected the strategies that health visitors adopted to gain entry to families and sustained interactions at superficial and ineffective levels. The following indicate how CHNs determined if information had been openly shared with women:

> ...we can often discuss what's on the referral form as long as it's reasonable. We go in and we say "We have received a referral from the hospital and we

> noticed that you went into prem labour or you spent some time in special care, want to tell me about that?" So it's used as an opening really and get some conversation going with mum and see what her feelings are about what's happened because maybe what's on the form might not be how she sees it. So it is very much using that partnership, open questions and find out how mum feels about it. (C9)

> It might be that we see that on the referral and can say to the client "Oh I have noticed that you have had some contact with mental health are you happy with that or are you following on for that?" and they might say to you "Oh yes I am seeing my private psychiatrist or no I'm involved with mental health". So I would be hoping that she has seen that referral, that it is an open referral. That she has seen what's on there so it is OK for me to discuss that with her. (C1)

Interactions that are based on the belief that some information cannot be brought to discussions between CHNs and women would negate any claim to transparency and hence the partnership ideal. Shared knowledge was important in reinforcing the concept of partnerships in care and in reducing perceptions of power inequities in professional and client relationships. The knowledge process, however, was professionally dominated and so the notion of shared knowledge denied the reality of selective sharing. Unequal sharing of knowledge maintained dominant definitions of situations for the purposes of control and shaped interactions in particular ways that produced conflicting perceptions of collaboration.

6.5 CONCLUSION

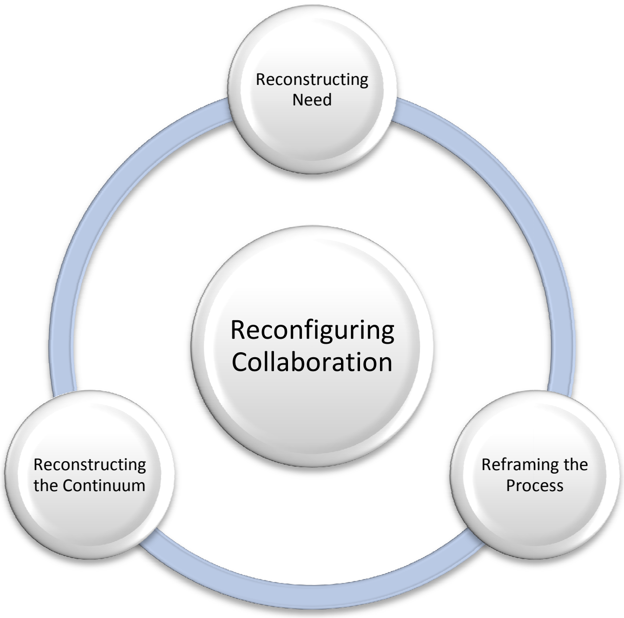
This chapter has explored three key processes by which midwives, women and CHNs engaged in the construction of incomplete and tentative knowledge that characterised interactions in the care continuum. First, the concept of negotiating knowledge boundaries reflected how knowledge was constructed in ways that legitimated the dominant position of specialised professional knowledge. Second, despite the work invested in constructing an order to knowledge this situation contributed to uncertainty that placed limits on interactions. Finally, the chapter explored the selective sharing of information and how this sustained certain dominant definitions that conflicted with the notion of transparency and partnership. The CHNs and midwives referred in an unproblematic way to the coexistence of expert professional knowledge with partnership and transparency in practice. The language of partnerships and teamwork served the dual function of legitimising the expert role and sustaining an impression of women as experts in their own care. Rather than representing a shift in the way healthcare is carried out, collaboration (as partnership) functioned as a device for reconciling divergent interests. This had consequences for interactions that revealed the contradictory formulations of collaborative work within the research context. The following chapter takes elements of the argument further to explore how healthcare institutions were continually reconfigured to negotiate similar contradictions.

Chapter 7: Reconfiguring Collaboration

7.1 INTRODUCTION

The third of the analytical chapters explores how midwives, CHNs and women engaged with and worked around conflicting interests embedded in institutions of care. Institutions refer not to inert cultural logics or representations but rather the broad structures of meaning whereby actors organise activity in social contexts (Hallett & Ventresca, 2006). A disjuncture existed between what was defined as ideal in interactions within the care continuum and what was actualised and this meant ongoing activity to reconcile differences. The implication is that the care continuum exists as a whole where conflicting interests are readily resolved to convey a sense of order. Yet participants circumvented prevailing views and language in ways that reinforced specific interests and revealed ambiguities and contradictions around collaborative work. In developing the argument this chapter explores the process of reconfiguring collaboration through the three key concepts represented below:

Figure 3 Reconfiguring Collaboration



7.2 RECONSTRUCTING NEED

While the historical underpinning of patient care is the organisation and recording of patient problems (Weed, 1968) the process of identifying problems has evolved in and been adopted into practice in different ways. Where the biomedical model dictates that patients present to health services for curative care, the model of which CHNs and midwives spoke had a different approach. The language of the CHNs and midwives emphasised women as clients with health needs. The assessment of need implied individualised care that assisted women to determine healthcare priorities. Yet an underlying agenda existed whereby need was used as a tool to sustain organisational imperatives and the professional role. The following illustrates how the needs of women were reconstructed to support certain priorities in this case a breastfeeding imperative:

> ...if you are a priority it means we should see fairly soon, like very soon. We do refer them to the early feeding clinic but if we want them to keep breastfeeding we have got to look after them. So you have got to prioritise and (tapping the desk) priority means a week maximum to see. (C1)

The *Australian National Breastfeeding Strategy* posits that everyone needs to protect, promote and support breastfeeding because breastfeeding is constructed as "the biological and social norm for infant and young child feeding" (Australian Health Ministers' Conference, 2009, p. 1). Yet where priorities are reconstructed as social imperatives the individual needs of women are brought into conflict with established norms (Ludlow, et al., 2012). The following explain how needs are reconstructed as imperatives in ways that limit individual action and shape choices:

> ...and they are like "you just have to persevere, you've just got to keep going." And I am like "Well I have got very sore, cracked nipples what can I do to sort of try and help ease that?" "Well you just have to keep going because breastfeeding is best and she needs to breastfeed so you just have to keep going, you just have to see yourself through the pain." (W3)

> Well if someone really clearly said that it's very concerning that he's not putting on weight I wouldn't have mucked around. I mean that's enough to breastfeed him but my priority was for him to put on weight and develop obviously. So if someone had said that weight, it's still a gain but at the same time it's rather a concern, so if someone had said that to us a lot earlier then

> we would have made that decision a lot earlier and we didn't have to wait for two weeks and he didn't have to wait for two weeks to start putting on weight. (W9)

The needs of women were shaped into professional and service concerns in the same way that most life processes, including childbirth and parenting, become professionalised and medicalised (Conrad, 1992; Knaak, 2010; Thompson, et al., 2011). Professionalisation and medicalisation processes reconfigure non-medical problems as medical issues which allows occupational groups to claim privileges and control over markets through exclusive rights to practice (Boreham, 2002; Larson, 1977). Where problems are defined in medical terms, medical language is applied, medical frameworks are adopted to understand the problems and medical interventions are implemented to treat them (Conrad, 1992). The medicalisation of healthcare has impacted nursing and midwifery practice because structured health needs and risk assessment tools have become embedded within care processes as institutions. The assessment process was a central factor in the research context because once identified through a pre-determined format, women's needs were then reconstructed by health professionals so that significant aspects of women's lives were brought into a professional framework in a way that justified professional action. The following discussion of the assessment process illustrated how needs were shaped into significant, quantifiable risks which enumerated professional influence:

> So she walked out of here smiling and looking forward to seeing me next week. So from a score of 18 I think if I'd got her to do another one (depression scale) she would have scored a six, do you know what I mean. But as a midwife it's professionally so fulfilling to know that that girl with a score of 18 has left here without having to go to (the unit) because of the protective factors that she already has with her sister and her mother and her partner and also her support networks that are just a phone call away and they are all written down for her and off she's gone. (H8)

Reconstructing needs as risk created a tension between individual, professional and organisational and political requirements. In midwifery and child health practice there is a political imperative to intervene early in pregnancy and infancy to prevent longer term health conditions and to save costs. Yet the reconstruction of need sits awkwardly with the conceptualisation of partnerships around shared knowledge, shared responsibility and common goals. Where need is reconstructed as risk, professional, organisational and political priorities are given primacy over individual views. Concerns are legitimised through professional interpretive schemes; a process that produces unequal care relationships. May's (1990, 1995) earlier argument is still relevant in its assertion that the reconstitution of patient need is underpinned by technical vocabularies that reform the nurse-patient relationship into a set of formal practices directed at the patient and delivered by the nurse. For CHNs and midwives working with women professional and organisational imperatives become the focus of care and justify ongoing professional intervention. The following midwife explained this process:

> I try to identify women that are high needs. So anyone that has any psychiatric problems, any anxiety, depression, anyone that is a sole parent, a young mum under 18, an older mother that is over say, 40. Anyone that's got no support services, the partner and they might be new to Australia and non-English speaking background people. People that have got financial difficulty, medical illnesses whether it be physical or intellectual. So identify those ladies and then once I have identified them I go and see them. (H3)

To sustain an impression of shared goals, shared decision-making and choice the concept of a care partnership was invoked. Terms such as being 'in partnership', 'with woman' and 'woman-centred' have entered midwifery care as antidotes to the medicalisation of pregnancy and birth (Carolan & Hodnett, 2007) and act as linguistic devices for the definition of a "good midwife" (Reiger & Lane, 2009, p. 318). Transparency and partnerships, however, could not be fully realised. Communication of risk became informed compliance (Jordan & Murphy, 2009) rather than informed choice because risk created an obligation for CHNs and midwives to act. Negotiations with women were thus carefully, and at times coercively, shaped as needs were reconstructed to justify surveillance as this CHN explained:

> I work in partnership with them. I'd sort of say to them "What would you like me to do? I could come back and see you again or you can come to clinic. If I am doing a home visit I can come back and see you again. If I'm in a clinic and I make another appointment would you like to see me again or would you like to see one of the other nurses? What dates and times suit." So I work along that sort of thing, we'd like to keep an eye on bub, his weight

> or we are a little bit worried, or we would have that sort of discussion about why we would like to see them again. (C10)

The tension that existed for CHNs and midwives between working in partnership with women and the assessment of need has been reported in similar contexts (Appleton & Cowley, 2004; Cowley, et al., 2004; Kruske, et al., 2006). A further complexity was that the different assessment systems of CHNs and midwives meant that assorted information was recorded and passed on through the care continuum. Indeed, a veneer of secrecy was sustained around certain information because it was no longer shared equally with women. As a result, the transfer of information between hospital and community services necessitated further negotiation. Women were encouraged and 'challenged' by CHNs, to reveal information and bring this back into discussions to ensure transparency had occurred. This process was justified as important in building ongoing relationships as the following CHN explained:

> I guess as child health nurses we would see ourselves as very transparent so if something was written on the referral, first of all I would probably give the client the opportunity to bring it up doing an assessment with them. But sometimes you do have to challenge a client a little bit by saying what is on the referrals because I think that is part of building the relationship as well. It is written there and that has happened where they have not talked about something but then you will kind of bring it in and say well "I have this referral from the hospital." And that just gives them opportunity then to explore as well. "Oh this is your EPDS score" or "It says here you have had a history of cannabis use." So I would certainly include that in the discussion. (C3)

The reconstruction of need within a risk framework also opened up women's lives to surveillance by health professionals. This is because the presence of risk gives rise to and justifies surveillance and the professional imperative to be vigilant for new and evolving health risks (Armstrong, 1983, 1995). This rationalises the professional role in the care relationship and its more powerful position. Furthermore, the professionalisation process differentiates risk and surveillance in ways that sustain distinct professional roles. The public discourse is that women, as responsible healthcare consumers, should be responsible for their own decisions. Yet the reconstruction of need as risk positioned women as less responsible as the imperative for action shifted to CHNs and midwives. Responsibility around child protection is an example of this ideological systemic tension. For instance, the notion of partnership has been contested in child protection work because health professionals cannot abrogate the responsibility to act on behalf of the child (Morrison, 1996). In the research, and in the case of child protection, responsibility was positioned with CHNs and midwives and away from the women thus constructing a hierarchy of responsibility. Where women were defined with risks and did not engage with services responsibility was transferred through mandated processes as justification for ongoing professional surveillance. The following illustrates how imperatives are driven by professionally defined risk:

> If they don't want anything to do with us there's not much we can do about that because we are a voluntary engagement. We can't force anyone....And if they don't want to be home visited they can come to the clinic which is fine. And then if there's someone with particularly high risk factors that totally doesn't want to engage with us we will let the hospital know and potentially child protection depending on what is on the form. (C8)

In risk averse situations people are categorised as types, because this is how risk is collectively identified and communicated. Risk assessment models sanction the process and form the basis by which professionals work together because professional action relies on the identification and communication of risk to maintain surveillance. The typification and institutionalisation of risk functioned to sustain models of surveillance and justified professional action which meant that midwives were forever vigilant of women as indicated here:

> I think they (SCN) view mothers as the ones who are actively trying to be with their babies, feed their babies, understand their babies, that's one group of women, and then there is another group of women who need to be encouraged to come, need to be, you know monitored in case they are not connecting with their babies. (H1)

> You will find often that if it is a DOCs case those girls will come in and go out very, very quickly because they don't want to be identified. So they try to get in birth suite and out very quickly and hopefully they won't be contacted. And in days gone past they did slip through the system. But now I

> go through everything right from antenatal through to postnatal to make sure any referral that they require is done. (H5)

The shift in control meant that health professionals determined the degree of autonomy attributed to women. In some cases surveillance was underpinned by systemic factors that maintained professional dominance over decisions, for example, around systems for child safety as noted above. In the situation where CHNs and midwives reconstructed need as risk surveillance strategies gained primacy over open negotiation with women. The decision about where to intervene and where to allow women to take control was at the discretion of individual CHNs and midwives as the following indicates:

> ...the women who are at extreme risk need extra surveillance whereas women who are just following the route of a normal birth are able, well other women are able to make decisions too, but generally they don't have life threatening impact. For example if you're dealing with someone with domestic violence or something like that they need to have closer supervision to make sure that nothing happens but if you don't have that high risk scenario, you step back and let women live their lives. Sometimes you need to intervene more because of the risk....But I have very clear guidelines about what I am able to do, as far as stepping forward. (H10)

Sometimes monitoring was a shared responsibility between women, CHNs and midwives although different conceptions of risk often saw different degrees of sharing. Parents involved with child protection services have reported that professional monitoring of behaviour appears to take primacy over support even where parents openly acknowledge a need for services (Devaney, 2008). In other situations responsibility for monitoring was strategically managed, for example, where midwives and CHNs engaged others in the monitoring process such a woman's family. The following illustrated how partners and families were engaged in sharing this role where risks around some conditions were deemed significant:

> So their risk of relapse is something like 80% post birth. So during the pregnancy we will be just keeping a general eye on them....We might see them two or three times during the pregnancy, that's what I mean by it is all sort of low risk. One of the visits is at 35 weeks when we get them to bring their partner so that way the family know. You have got to have the family know with these women. (H7)

Women defined and constructed need and risk in ways different to CHNs and midwives. Sometimes this was because risk was conveyed in a way that resulted in doubt and fear which set up a process of vigilant self-management. As has been argued elsewhere, risk becomes enmeshed with consumer responsibility for health which gives rise to an imperative for 'self-surveillance' (Armstrong, 1995; Clarke, et al., 2003). At other times women mediated risk by contextualising it within personal needs. The following indicate how women reconstructed the risk imperative as self-surveillance which was exemplified in different ways:

> I've also been told point blank, mums of premmies are at high risk of PND too. So I've been told "okay, you've got a 50/50 chance because you've had it before, now you're at higher risk because you've got a premmie." So righto, alright, let's make sure, keep a good eye on myself, keep an eye on what's going on around me and keep in with resources and make sure I've got at least an understanding of what to do with her. (W10)

> ...there are so many guidelines and things you need to follow and be aware of these days sometimes it's just best to let it be and I don't need to get paranoid if they're kicking the covers off when they're in their cots...or with all the guidelines of what to do and what not to do. You've got to take a step back and just go "okay, it doesn't matter that they're not swaddled" or that's come off in their sleep and they're not going to die, to have sudden death. (W6)

Reference to partnerships, transparency and equal relationships in the research belied the existence of institutional imperatives and professional interests and hence power differentials in interactions. While the ideal of partnership suggests a different way of utilising power and authority this can be difficult to achieve and sustain in practice (Fowler, et al., 2012; Kruske, et al., 2006). One reason for this is the imperative for action initiated through the professional assessment process. Further, embracing partnership in practice requires continued work by health professionals to avoid slipping back into "default talk-and-advice-focused" models of practice (Fowler, et al., 2012, p. 3312). Findings in this research indicate that, for CHNs and midwives, there existed a fine line between advising and suggesting and therefore between being an expert and a partner in care when working with women:

> I have to listen to what they really want. I don't just recommend something that I think will work, I ask them first "what do you want, what do you feel you need?" and if they ask me for suggestions then I put in or if I think that they need a suggestion I put that in... (H10)

> If it is a first visit we usually spend a lot of time just doing a family assessment and just talking to the client about what's been happening for them, looking at their past, perhaps looking at their background, their childhood and just gaining information to give us a picture of what has been happening for the family and then of course we will get a look at the baby and just answer any questions the client might have and make a plan about what we are doing to do, what does the client need. If it is complex often we will have to almost encourage that client that "We would like to see you again." (C3)

Other subtle power differences were evident in the need reconstruction process. In exchanges between CHNs, midwives and women there were subtle shifts between freedom of choice and control. One mechanism for this was the transfer of imperatives through use of terms such as being 'worried' much the same as this operated around fear and doubt. The expression of being worried was used as a vehicle for shaping need and influencing choices and thereby justifying the professional role. The following exemplars from a woman and a CHN explain how the concept of being worried shaped need:

> So we weighed her and they put a note and they said "You can come in again on Tuesday if you're worried." She got discharged on Thursday, so they gave me an appointment on Tuesday to come in and weigh her so that they can see and they would give me four or five days to do it on my own and they could again see the result before it gets too late. (W4)

> So I said to her "Look I am going to make a referral. I'm a bit worried that he should be standing, are you worried?" "Yes I'm really worried." "OK what would you like to do? We have the child development I can make a referral to that for you, are you happy to go there, they will contact you and things like that?" "Oh yeah that would be really good." So it's because she was really worried, it makes it much easier. (C10)

Power operates where surveillance is justified in the reconstruction of need as risk which is then a professional matter. This is not to negate the fact that CHNs and midwives work hard to manage the tension between professional power and partnership (Wilson, 2001). Shaping conversations carefully is required if professional and organisational objectives are to be achieved around the care of women and their babies. For example, framing the idea of surveillance as routine practice shapes interactions in more coercive ways. Chalmers referred to these as "closed context" situations where women may not have requested or agreed to a service and so health visitors adopted different strategies to gain entry to homes such as framing home visits as "routine" (1992, p. 1320). A further strategy whereby health visitors negotiate power and partnership is in identification of a need or problem from the client's perspective, giving assistance to help meet a need and thus gain legitimacy in the early stages of relationship building (Chalmers, 1992). Health visitors thus engage in a combination of tactics to make their services acceptable, relevant and accessible to clients, in essence to gain clientele and influence behaviour, akin to "marketing" of services (de la Cuesta, 1994, p. 349). This reflects what Scamell (2011) refers to as the vigilant professional who is so consumed by managing risk and surveillance that the appearance of the swan is assumed, looking serene on top of the water but with madly flapping feet below. The following depicts the precarious nature of the process whereby CHNs and midwives worked hard to engage women and maintain surveillance while countering potential resistance:

> Sometimes (midwife) and I will have a plan that we might go out five times and so I will document that, you know we would be liking to see this patient at least more than the routine and don't let her say "Oh she only needs that one visit", if you know what I mean without being pushy or whatever, "Oh we will come and see you" rather than "Do you want another home visit?" So we are saying we will see you as your needs require but we won't give her that option. She always has that option but I think sometimes if you are not giving them in their brain that option they are happy to go along with us seeing them three or four times instead of saying after one visit "I don't want you seeing me anymore." (H6)

Resistance from women to intervention on the basis of defined need was perceived by the CHNs and midwives as an act of deviance. The challenge then was how to strategise engagement with women. The following indicate how CHNs and midwives saw the face-to-face situation was the best way to convince women of the need for services:

> ...often once people are engaged with child health they stay with the service but getting that initial engagement, people kind of go “Oh yeah I don’t need it” or “isn’t that just for people who are having problems, I’m OK I don’t need child health.” But once they have had the home visit they tend to stay engaged with either more home visits or other services that we have to offer. (C4)

The model of dependence that underpinned need, risk and surveillance limits autonomy for women because the need reconstruction process encourages women to seek professional advice rather than exercise personal initiative. This breeds a “climate of passivity” between the individual and the professional helper (Furedi, 2006, p. 164). Furthermore, socially disadvantaged women are differentially influenced in this process so that the fear of repercussion in not taking expert advice results in “silent compliance” as delegation of decision-making to the professional occurs (Ebert, Bellchambers, Ferguson, & Browne, 2013, p. 1). The following point to the existence of a hierarchy of knowledge and control that underpin the dependence model and privileges the professional position:

> Well I think family is your ideal support but professionally they need, well they need to have child health or something similar around them to educate them really. (C1)

> ...if women know that they can come to us before they have a massive problem...we can do the early intervention and we can do the primary care stuff...if people come and see our service on a regular enough basis they don’t get themselves into strife (and) everyone is happier in the long run, us included. (C4)

The way that need was reconstructed to support dominant interests also extended to other processes. The following section addresses how the care continuum was also reconstructed to sustain a professional role and the implications of this process for interactions.

7.3 RECONSTRUCTING THE CONTINUUM

In addressing what was referred to as gaps in the transition of care participants brought into question the concept of a collaborative system working in a care continuum for women. For example, the concept of a care continuum implies an unbroken process of care focused on clients. The conception of the final stage of maternity care as hospital post-birth care has been challenged by reviews into maternity services both locally and nationally (Hirst, 2005; National Health and Medical Research Council, 2010). Yet despite maternity care being defined as community midwifery to give the impression of a care continuum beyond hospital settings (Homer, et al., 2002), recurrent references persist on this as a discontinuous process (Department of Health and Ageing, 2009). In the research the notion of a gap at discharge reinforced the idea of a discontinuous process because health professionals were no longer monitoring the situation. Midwives and CHNs saw this as losing control over the situation which required specific action.

Women were discharged from hospital once they were well while babies gradually gained in health while in the SCN. During this time women visited their babies in the SCN, attended to their feeds and cares and then some returned to the hospital for a brief time to 'room-in' before the baby was finally discharged home. In some cases women were asked to return to the hospital after discharge to have the baby reviewed. The time spent in the SCN medicalised what would otherwise have been a 'normal' experience through surveillance of the mothering role and the health of the baby. The following midwife explains this process:

> With any woman who is leaving, whether she's special care or not, we observe her mothercrafting and see how well she is managing it, does she respond appropriately to the baby's cues for care, is she seen to be doing the things that we expect her to do? For example, timely feeding, taking care of hygiene, is she gentle with the baby, is she safe, is she exhibiting any behaviours that show stress or an inability to cope. (H10)

The expert role of the health professional was inserted into the process very early on because of the health needs of the baby so women were perceived in need of ongoing support and surveillance. Surveillance was represented in divergent ways. On the one hand, the health professionals saw the staged process of discharge with a return to 'rooming in' as an opportunity for women to manage full time care of their babies where neonatal nurses and midwives would be available if assistance was needed, as reflected above. Women, on the other hand, thought that it was health professionals that needed reassurance about the readiness of the baby to go home. The following indicates a woman's perspective on whose interests the process served:

> They like you to room in because they like to make sure that they've made the (right) decision or if something goes wrong, because they took her off the monitors, she wasn't on those monitors, she wasn't on the breathing things anymore...(W3)

The shift of surveillance, and hence responsibility, to women was nonetheless a concern which had elements of uncertainty for most of the women and specifically the first-time mothers. Even though a number of the babies had spent considerable time in the SCN, preparation for discharge usually commenced some time ahead so that women would know what to expect. Although there were designated education and information activities for women in preparation for discharge, women talked about taking their babies home with some trepidation. The following indicates this:

> ...all I wanted to do for five days was take my baby home and then it came to the day and "You can take your baby home." and you're like "My God I can take my baby home what do I do now?" (W2)

The sense of doubt contributed to the rationale for ongoing surveillance by hospital staff. The notion of 'abandoning women', leaving women 'vulnerable', 'abrupt ends' to care and leaving women 'out on a limb' were expressions of how the care transition was problematic for CHNs and midwives. What was not equally recognised was the role of women in the care continuum process. The following excerpts illustrate how the continuum was objectified as a problem because the monitoring and support for women in the hospital was ending and there was an unknown period before the baby would be seen again by health professionals. Action was required until surveillance was taken up by others as expressed by the following midwife:

> ...we would give them that little bit of TLC, support whatever you call it so that hopefully to transition to home and then for child health to cut in, that bit more closer. You know we are not leaving them out on a limb so to speak. (H6)

As noted previously, authority is reinforced by ensuring compliance through doubt, risk and fear. This is not fear as an individual construct but rather how fear operates at a social level because risk is adopted as a social reality and sustained through processes of professional assessment and surveillance. Furedi suggests that the “precautionary principle” - to be careful or else assigns a minimalist role for human agency that negates choice and depicts people as essentially powerless (2006, p. 176). The following indicates the power of socialisation in the compliance of women to ongoing professional surveillance:

> Certainly when they are asked to come back for weighs they seem to feel they have to, that’s very important, that they need to do that. (C1)

> ...even after his discharge we went back to special care nursery a few times because for one thing they want him back just to check if he’s putting on weight and also his jaundice level, he was a bit yellowish when he was born. (W9)

Where women are assigned a minimal role in self-management this implies health professionals are best situated to determine and meet ongoing needs. For the midwives the gap between professional services created uncertainty because they were no longer in the key position to meet needs. The situation was not one continuous, shared, normal period during which women could self-manage because health professionals were not connected and women were not in control. In some cases the response of midwives was to intervene and ensure ongoing surveillance after discharge. This was conveyed as the norm and justified as evaluating care. It also reinforced the existence of the continuum as problematic:

> That’s one of the other aims of our follow-up phone call is just seeing where they are at, what are some of the issues that they are facing with parenting, what are some of the difficulties and do they have those avenues of referral and really is a bit of an opportunity to reaffirm or to remind them of what those services are available to them...we have had such intensive involvement with these women up until they deliver and then we don’t exist. We don’t hear or see them again which I think is a little bit of an abrupt end to that episode of care. One thing that it does is, I think, enhances the continuity that we are able to offer, that we are able to touch base with them postnatally and really see how a lot of those things, the issues that we were

> dealing with antenatally were, very often things that you were preparing them for in parenthood...So it's also very helpful to touch base and see how relevant was any of that and was it useful and are there ways that we can change and improve what we are doing antenatally to help make that postnatal transition to parenthood a little easier. (H4)

Ongoing monitoring meant that the women were seen as less active in identifying and meeting their own needs and this allowed health professionals to take up this space. Engagement was strategically planned by CHNs using need to reinsert the professional role. Wilson (2001) and de la Cuesta (1994) described how child health nurses and health visitors would put in extra effort around initial home visits to 'hook' women in to this ongoing role. The following reflected how CHNs strategically positioned themselves to engage with women. The optimal time for engagement was when midwives had ceased home visits and there was a space to be filled as this CHN explained:

> ...we don't contact while (midwife) is still involved because often the Mums are dismissive. "I am still being visited by the midwife." Hang up. "I don't need you." Hang up. So we wait for the midwife to not be involved then we will ring a couple of days after that. "How are you going? Have you got any questions?" Because if it's while (midwives) are engaged or straight after; "Oh I have got no problems because the midwife has answered all that." The mums don't necessarily recognise that child health would be of any value to them. So we really try and are careful with that timing. (C8)

Discharge planners, liaison nurses and discharge coordinators were examples of specific roles positioned to bridge the gap between services. Similar roles reported in the literature reflect how this is thought to constitute collaboration and seamless care because the assumption is that people in the roles bring together disparate groups to share accountability, language and information (Hibberd, 1998; Long, et al., 2013; Williams, 2011). Furthermore, CHN and midwife participants suggested that such roles were important because of the discrete domains of hospital and community care and that professionals coordinate and manage information more effectively than women. The following CHNs explained:

> ...I think unless you have got a liaison sort of person to do that, it's too separate, community is very separate to the hospital environment unless there is someone to coordinate it. (C1)

> It’s the same with having the discharge facilitator at the hospital....It just gives you one central place to contact so you don’t have so many fingers in so many pies and it means that things don’t get missed as much. (C10)

A further and related point was how the baby became the means for CHNs and midwives to reconstruct the care continuum as a place for the professional role. As an object of professional action, the baby was used to achieve entry to families at home because the baby was an object of common ground in negotiations and a starting point to sustain surveillance. Shepherd (2011) similarly described how CHNs use the visible act of weighing babies to gain access to and covertly assess the emotional health and wellbeing of women in the postnatal period. The baby is considered a legitimate means to open up negotiations with women who would otherwise be difficult to engage. The following illustrates how CHNs positioned themselves using the baby to gain legitimate access to parents and to maintain professional surveillance:

> You have a client group whose risk factors may be, who often haven’t engaged with health ever...they don’t necessarily trust the system sometimes. And having a baby is seen as a really good opportunity to get a foot in the door. (C8)

To sustain the professional continuum CHNs and midwives needed to convince each other about the concerns and priorities that were relevant within one professional area and yet more tenuous in the other. The categorisation of women into priority or ‘targeted’ groups was one means of conveying the imperative for surveillance and therefore ongoing professional action. The application of a common language around referrals functioned to carry the imperative and create the impression of joint action. Yet resources impacted upon negotiations so that consensus on follow through was not guaranteed with all services. At times exchanges reflected an ‘us’ and ‘them’ approach rather than a continuum focused on the women as indicated here:

> And I tell (child health) what is coming, who has gone home, these are the targeted, urgent cases. And then I say “will you be able to see them?” So I always know they are getting followed up pretty quickly. When it comes to (different child health service) it is more difficult because they don’t have the resources to do that and they tell me that a targeted referral might not get

> any contact for four weeks which is a long time. The whole idea of my job was supposed to smooth over that sort of big space between us and child health. (H5)
>
> I mean for me child health is always an extension of midwifery and I think we need to value each other's service more and at the moment it really seems like there are midwives and there are child health nurses and for the client, for the staff, I feel there is a gap, a big gap. (C3)

Women thought that information flowed freely between services but came to realise this was not necessarily the case. Their view was that professionals were responsible for communication which challenges the political and professional polemic that patients seek control of their personal health information and want to be involved in negotiated care with health professionals (Australian Health Ministers' Conference, 2011; Department of Health and Ageing, 2010; National Health and Hospitals Reform Commission, 2009). At times women assumed a role in addressing gaps in communication by informing CHNs and midwives about what each group was doing which reinforced how the care continuum was perceived as a professionally maintained space. The following woman explained:

> I don't think they communicate about certain cases, individually, I don't think, so they're not aware of what the other one is doing. So for example I've been back to the hospital, so I told them I met with the community health nurse and this is what they suggested and then when the child health nurse comes here, I tell them I have been going to special care nursery for, follow up appointments and this is what I have been doing as suggested. (W9)

While the process of reconstructing the care continuum as a professionally dominated space was ongoing there were other ways that different interests came into conflict. The following elaborates on how processes were continually modified to address different interests and thus position the authority of professionals.

7.4 REFRAMING THE PROCESS

The ideology of institutions is that they manage the ever changing world in ways that limit uncertainty, keep chaos at bay and convey an impression of order (Berger & Luckmann, 1966). The significance of institutions is based on social recognition of them as ‘permanent’ solutions to ‘permanent’ problems and legitimated through ongoing action that continues to confirm this function (Berger & Luckmann, 1966, p. 87). Multiple factors in the care continuum challenged this assumption, not the least of which was the tension between the ideological positions of different interests. While guidelines, rules and set processes directed how collaboration would work participants also described how situations were continually reframed to meet different demands. This created an ongoing tension between reconciling individual, professional and organisational needs.

It was argued earlier that the processes of typification, categorisation, and systems of relevance simplify and render identity and knowledge manageable (Berger & Luckmann, 1966; Hogg, et al., 1995; Tajfel, 1978; Wagner, 1970). The processes instil order by constructing realities in certain ways that make sense to people and become templates for decision-making. The realities represent institutions or working models for interaction and exemplified as rules, processes and guidelines for action. The implication is that institutionalisation functions in limiting the flexibility of individual action so that variations do not threaten the established order (Berger & Luckmann, 1966). Midwives and CHNs described how set processes could be consistently applied to most situations to allow an orderly work flow and achieve what needed to be done:

> We have a lot of clients to see and that process allows us to see the maximum number of people that we could see because if we had a less complex or looser structure I think you would spend a lot more time in administrative tasks and it would be much harder to see that many people in one day. (C4)

Not all situations, however, were subsumed within this systematic order. This meant that what was ideal and what actually occurred often diverged, challenging the notion of order. At times this involved the circumvention of processes to serve particular interests. In other words, CHNs and midwives would alter criteria and shift boundaries to extend their influence or reinforce professional control. One of the processes referred to earlier as ‘boundary work’ (Fournier, 2000) describes how professions manage their professional borders in ways that continue to justify and legitimate desired positions. In this way processes could be reframed to support the specific needs of women and appear flexible but in a way that sustained professional control and maintained surveillance. The following explain how boundaries of care could be reconfigured in this way:

> Even our out of area women, if we have seen mental health patients that have come to our service but they are (out of our suburb area) and the Psych CNC has asked for us to do home visits we will go and visit them. It's not a done thing but it is those high risk clients that we can just accommodate some people. (H6)

> It is just a case of being a little bit flexible. You can't just go "no they are out of the area". You have to really triage and say "Oh look who needs it?" (H5)

This was seen as being flexible and framed as a moral imperative where the need to be inclusive became the rationale. In other words, circumventing rules, sometimes an arbitrary act, reinforced a responsiveness to individual needs while also maintaining professional authority and dominance. It also sustained a dependence on services seen to be responsive and relevant to women.

Yet there were limits to this flexibility because the ability to alter processes was differentially distributed among participants. Some things were more negotiable than others and this meant that key people decided how different professional and organisational needs would prevail over individual needs. The issue was how limits were negotiated and justified and how differing interests were addressed. For example, in some cases rules could not be changed, while at other times there was greater flexibility. The following reflect the contradictions and give the impression of arbitrary decision-making:

> I did talk to one of the supervisors one night when I was sort of asking whether I could stay (longer in hospital) and she was quite, again because she's probably seen it all before, and my twins weren't that critical, they weren't in intensive care, so she was quite blunt. "You don't need to be here." sort of thing, "take the opportunity to be at home while you've got it." (W6)

> ...we were just worrying thinking "well we don't want her to move, it might be taken out of our hands." Apparently someone high up in the nursing team was pressuring (the doctor) saying "she's got to go back to (other hospital)" and so there was this to and fro but finally when the CNC rang and said

> “she's not going anywhere” that was great because then we could just move on from that. (W10)

While some CHNs and midwives did not have the necessary authority to change some processes women were encouraged to take action if this was perceived as more effective. In the following exemplar, a woman participant describes how she enlisted the assistance of a CHN to gain an understanding of how to circumvent the clinic appointment system:

> ...when we had our session with (CHN) we asked her people’s hours. We said “What day does she work?” And stuff like that and “When do you work?” And she said “Well I always work Friday mornings so that is when you can try. Try to ask for a Friday morning appointment and you will probably get me.” (W1)

At other times participants were able to strategically reframe situations in ways that met a number of different interests concurrently. For example, funding was described as a controlling factor in what services were provided to women. Yet, circumventing certain processes, while framed as meeting the needs of individual women, also served to extend professional influence. The following suggests how ‘unauthorised work’ could be reconstructed to sustain service demand, justify the professional role and secure ongoing financial support:

> If somebody is out of the area I will get them in. I will say “Can you come up to the hospital and we will just weigh your baby quickly?”....Which we never have been really funded to do, we have just really done it. So now next year the activity-based funding is coming in we are going to be recording all of those. (H5)

There were limits to the reframing process particularly where there were conflicting philosophies. In these situations cooperation was required to avoid conflict and to accommodate shared goals. Blumer and Mead drew attention to how people align acts in commonsense and pragmatic ways albeit based upon any mixture of reasons such as compromise or even out of duress; using one another to achieve respective ends because it is convenient, necessary or just sensible to do so (Blumer, 1966). Their point was that joint action did not require participants to share values but rather that lines of action could fit together because both could identify with the joint action and could see their part in forming that joint act (Blumer, 1966).

Similarly, Goffman (1967) suggested how joint contribution to a single overall definition could allow rival definitions to be concealed so that situations could be handled in an acceptable way. Where different views existed between CHNs and midwives about what constituted service priorities this affected how referrals would be acted upon. To meet the needs of women this could be negotiated by reframing the definition of what constituted priorities as explained by this CHN:

> In some circumstances, but rarely I guess, we would be asked to get them in, in the next week or something but hopefully the hospital has dealt with any major issues. So it’s not an emergency situation but we do try to get them in early regardless, when they are priorities. (C6)

Negotiations, however, became more difficult when coercive processes were used to alter definitions. Conflict occurs where either side is asked to act in a way that conflicts with a valued ideological position. The result is a perception of coercion particularly where the needs of women were placed between the conflicting positions. This exemplar illustrates how a perception of coercion was negotiated where the priorities of maternity services conflicted with those of child health services, in this case where a woman had been offered a service outside what child health considered as routine practice:

> The difficulty has been when “I have told this mother you (child health) will home visit them, you need to ring her.” “Well actually it would be great if you could send me a referral because we don’t routinely home visit for that.” But you know send me a referral with all the information, if there’s any psychosocial stuff then I may be able to add into that, or medical that might because we are not an acute service and we don’t crisis respond. (C8)

Aligning actions required compromise because of differences over what were considered ideal processes. Institutions are constructed around personal, professional, organisational and political ideals; ideals about what is typical, normatively expected, probable, desirable or in accord with certain cultural norms (Stokes & Hewitt, 1976). ‘Real factors’, however, regulate the conditions under which the stated ideals appear (Berger & Luckmann, 1966, p. 20; Scheler, 1960/1980). Where set processes are constructed to control variation and provide some guiding order in complex situations this may conflict with personal and professional ideologies. For example, the ideology of woman-centred and individualised care sits in conflict with priorities that target those identified as disadvantaged and in need of care (Hart & Lockey, 2002). The assessment process that privileges certain need is also used to ration health services which calls into question professional judgement processes and places limits on practice (Cowley, et al., 2004). Furthermore, while nursing practice is legitimised through manipulation of patient need, unreasonable demands are placed on nursing practice that invoke professional responsibility through surveillance (Armstrong, 1983; May, 1995). The following indicates how service criteria restrict professional practice:

> ...because families have to meet such strict criteria we were unable to home visit families who were literally begging us to come and visit them because of multiple factors or reasons why they found it difficult to get to clinic or difficult to fit in with the strict appointment times with clinics or the strict days involved with clinics. We're unable to home visit those people because of those strict guidelines and from a practitioners point of view it was frustrating and it just makes you feel frustrated with what you are doing in your job....People were asking for help and we were not able to give it to them whereas you often find that if you are only visiting people under strict criteria they don't necessarily want to receive your support. You are kind of offering them support that they don't really want when there are people out there who really do want it and aren't able to receive it. (C4)

One way that CHNs and midwives reconciled conflicting demands was to elevate significant features of a role and remove others of less significance. This indicated a pragmatism that disputed the notion of institutional control. The following example indicates how changes could be made to roles so that important role functions remained relevant to women and the profession, while others were assigned lesser importance such as paperwork and collecting statistics:

> ...just a couple of weeks ago I said to myself "What am I doing here, why am I doing this, when I don't really need it to be done as part of my role to do the referrals?" But that was just the decision that was made when the person set up the job so I have cut that out....But I have cut a lot of things out that were being done that I didn't deem as to be particularly necessary. (H5)

Reshaping roles reflects how institutions were continuously reframed to maintain relevance. This is how people and the professions engage in processes of repositioning to remain significant in competitive social systems. This was discussed in previous chapters around identity and knowledge but also applies to institutions because of the ever present threat of change. The following indicates how CHNs and midwives were able to redefine parts of their work to remain relevant in the face of systemic threats such as funding and resourcing cuts:

> Everybody said “you are meant to be seeing complex clients.” And we were all like, “We are.” And they said “Well they are not complex.” So (midwife) and I changed what our definition of a complex client was and now we can meet it. (H3)

As previously indicated, institutions or working models for interaction, are exemplified as rules, processes and guidelines. They become proxy authority mechanisms to keep the redefinition process in check and sustain institutional order. The myth that rules and set processes work effectively is inherent to social life through the multiplicity of human beings and interaction. Yet it is the very idea that rules remain tacit and not fully shared that allows organisations to function effectively (Manning, 1977; Musolf, 1992). Furthermore, the process of negotiation around rules indicates how those with the most power can influence interactions disproportionately because authority to circumvent rules is afforded to key people at key points. The ability to reframe situations reaffirms a professional hierarchy of responsibility. The following indicate how legitimate authority could be used to negotiate around rules and processes:

> I would still recommend that they contact that same person or suggest that the nurse does and then if they meet a stone wall of “I don’t have consent” then this is the next step. Sometimes I just jump that next step... (C8)

And:

> ...some of the reasons that I might be the one making those phone calls is because I have a personal relationship with the referrer or someone in (service) that I have met at meetings that I can ring up. And often, (health service) particularly, will say to my clinicians, “No I don’t have consent, I won’t discuss that with you.” Whereas if it comes from me to their manager they will access it and tell me no worries. (C8)

A further way that nurses and midwives managed potential threats to the established order was the formation of structured agreements between services. This most often occurred with other services where there were different governance structures and potential conflicts around care processes. An implicit assumption of an agreement was that it reflected shared goals. Yet agreements functioned as a means to maintain control over the behaviours of others and stabilise the effects of change because agreements could be used to manage deviance and keep processes on track. The following reflects how agreements were used in this way to ensure processes were adhered to:

> They have so many changeovers of staff so I say "when you ring if you feel like your concerns are not being taken on board just remind them that you are from child health and you do have a pathway with their service around this. Or if they don't want to feedback just remind them that we have a pathway and part of that pathway is that we get feedback within a certain length of time." (C5)

Legitimate processes were tangible ways to account for, describe and demonstrate shared work. Furthermore, where processes had to be negotiated and reframed around individual needs this involved more work and was time consuming and less legitimate because the process was less visible. Midwives and CHNs assumed that working with other health professionals in formal and structured ways constituted greater evidence of collaboration. The following indicate how ad hoc interactions between professionals were less visible and therefore less legitimate than structured work giving less meaning to collaboration:

> So when you talk about hospitals and us working together, I find there are times, a lot of times, that a child could be involved with the hospital that we are not aware of it. It's not always there on the referral but when we do engage and ring those people they are very keen to work together and are happy that we are involved in the community. So the actual relationship when it starts is good...and there was a lot of collaboration going on there but it took a lot of luck and it means that you really have got to get your information and find out the phone numbers and start calling these people and get things happening. (C5)

> ...I still don't think it's collaboration in the truer sense of the word. I think it's a bit ad hoc what we do. It's not a formalised. We don't have any formal processes to communicate with staff in those hospital departments, once babies are discharged. (C4)

The ideal of institutions denied the reality of how processes were continually reframed to support different interests and thus conflicting forms of collaboration.

7.5 CONCLUSION

This chapter explored the ways in which health professionals worked around conflicting ideals and interests in the care continuum. The research draws attention to the active work involved in interpreting the dialectic between institutional ideals or official rhetoric and ambiguities and complexities that were continually played out at different levels. The process of the reconstruction of need as a professional concern demonstrates how medicalisation and professionalisation of healthcare have consequences for interactions. The second issue concerned how the concept of a care continuum was reconstructed in various ways to allow CHNs and midwives to insert their expertise. This is not to suggest that the CHNs and midwives actively conspired to assert power and position in the care continuum. Rather it reflects the prevailing professional view that absence of the professional role in the care continuum is a concern. The implication is extended surveillance of women and expanded professional roles for CHNs and midwives. Finally the chapter explored the tension between the need to sustain an institutional order and the ideology of individualised care. It was argued how processes are set up as institutions to instil order and yet are continually manipulated to gain legitimacy for respective interests and to make things ‘work’. Furthermore, the capacity to reframe processes varied and hence collaboration conceals how flexibility reproduces control. There is an inherent tension in processes that sustain the professional role through accountability and responsibility while representing both organisational needs and woman-centred care. Despite apparent institutional controls, processes were continually reframed to gain legitimacy for respective interests while the impression of collaboration was sustained.

The following chapter will take forward the concepts addressed in this and the preceding two chapters as the basis for an analysis of the text of policy documents that focuses on the function of collaboration in healthcare.

Chapter 8: The Politics of Collaboration

8.1 INTRODUCTION

The objective of this chapter is to further explore the construct of collaboration as it appears in relevant policy documents. The key conceptual findings of Chapters Five, Six and Seven form the basis for a critical analysis of the assumptions embedded in policy text. The aim was to depict areas of convergent and divergent meaning. The policy text subject to analysis constituted Federal, State and professional nursing and midwifery documents. The chapter begins with an explanation of the systems-based ideology that underpins much of healthcare policy. What follows is an examination of the policy context wherein policy-making functions to frame collaboration where different interests exist as in the situation experienced by the CHN, midwife and women participants. The chapter concludes with a focused deliberation of the key conceptual findings around collaboration. The central argument is that the concept of collaboration serves functions in the policy context that obscures the complexities of the research situation as experienced by CHNs, midwives and women.

8.2 MAKING HEALTHCARE POLICY

Implicit in healthcare policy documents analysed in this research was a systems approach to collaboration. Although systems thinking was first used in the manufacturing sector it has also been adopted in healthcare policymaking (Palmer & Short, 2010). The basis of systems theory is that the whole of something is understood by considering how the various parts come together to maintain balance and equilibrium (O'Leary, 2007). The systems approach that commonly appears in the Australian policy context involves the stages of problem identification and agenda setting, policy formation and implementation, and policy evaluation (Cheung, Mirzaei, & Leeder, 2010; Palmer & Short, 2010). An example of the systems approach is the ‘program logic’ explanation of the *National Framework for Universal Child and Family Health Services* (Australian Health Ministers' Advisory Council, 2011, p. 38). Collaboration was evoked as a way of managing the challenges in implementing this logic:

> Universal child and family health services also work across traditional organisational boundaries and collaborate with education, social and family support services. Integrated and collaborative models bring benefits including reduced complexity navigating the system (e.g. a single point of entry which reduces the need for multiple assessment), more timely service delivery and provision of continuity of care across transition times, decreases the likelihood of families 'falling through the cracks'. (Australian Health Ministers' Advisory Council, 2011, p. 31)

As noted, a systems approach assumes the establishment of a common definition of a problem as a means of drawing boundaries around a system (Foster-Fishman, Nowell, & Huilan, 2007). Yet a shared view on what constitutes a problem can be difficult to achieve. Furthermore, problems generally only reach the political agenda if converted into political issues and this depends on the political will and lobbying power of different groups. Within this context, the concept of collaboration is used to suggest how shared understanding and commitment can be achieved by setting aside or suspending agreement on problem definition. This functions in much the same way that Goffman (1967) explained the veneer of consensus. Conklin explains this view:

> ...the Holy Grail of effective collaboration – is in *creating shared understanding about the problem, and shared commitment to the possible solutions*. Shared understanding does not mean we necessarily agree on the problem, although that is a good thing when it happens. Shared understanding means that the stakeholders understand each other's position well enough to have intelligent dialogue about the different interpretations of the problem, and to exercise collective intelligence about how to solve it. (2005, p. 17)

The nature of 'problems' in the maternity and child health area are diverse and ever-changing and highly dependent on those interests being represented. Change is contingent on social representations of the roles of women and their partners, social values on childbirth and parenting and also changing professional, organisational and political landscapes. A plurality of interests within healthcare has brought different views on how professions work with families and communities. Policy-making reflects how plurality is navigated through a process of consensus building. The policy process becomes a vehicle wherein claims are made visible and particular views are presented as the norm and rational. In other words, the process involves the posing of general statements about problems in ways that few would refute thus giving the appearance of shared meaning. It is within this consensus building process that problems are often framed as government concerns to justify control in terms of a common good. The following example of consensus building around child protection illustrates this point:

> There is widespread consensus that the best way to protect children is to prevent child abuse and neglect from happening in the first place. There is also widespread consensus that this requires robust primary and secondary systems for protecting children that provides families with the assistance they need before they come into contact with the statutory child protection system. (The Allen Consulting Group, 2008, p. vi)

A systems approach that sets the agenda and defines problems through references to collaboration and consensus implies that everyone owns a problem and everyone will share in preventing and solving that problem. This is how ‘whole of government’ policies are adopted in calling for services to work together across sectoral, organisational and professional boundaries by improving communication, attitudes and inter-agency protocols (Scott, 2005). The National Health and Medical Research Council suggest, in a rather circular fashion, how this translates as collaboration:

> If all team members or collaborating partners are cooperative and assertive, decisions will be made based on consensus. (2010, p. 19)

Consensus on an issue framed as collaborative action (or vice versa) assumes that theoretical models and frameworks can be logically applied to resolve problems. For example, the case for a public health preventive model is proposed in reference to child protection where problems are redefined so that authoritative approaches are replaced with localised, family oriented services. Using systems logic the complexities of this issue, identified in the research, are obscured. The following illustrates the logical deconstruction of this situation:

> The basic assumption of a public health approach to protecting children is that by providing the right services at the right time vulnerable families can be supported, child abuse and neglect can be prevented, and the effects of

> trauma and harm can be reduced. (Council of Australian Governments, 2009b)

The systems approach also makes assumptions about individual action. An example is the assertion that rational consumers will focus on preventing problems through health choices upon receipt of the right information (National Preventive Health Taskforce, 2009, p. 31). This logic assumes that people have the necessary resources for this process, will adopt the same perspective and will abandon their own views in light of policy wisdom. On the latter point, however, there were indications about how a desired outcome might require corrective and coercive measures if collaboration does not occur. The following demonstrates this shift:

> Where imperfect information, the absence of rational decision-making and negative externalities exist, there is a strong case for corrective action to be taken. (National Preventive Health Taskforce, 2009, p. 31)

The systems approach has been argued as a useful starting point and frame of reference for exploring policy processes although it is often criticised as overlooking the intricate complexities inherent to systems and in particular how complex social relations shape and form systems in many and varied ways (O'Leary, 2007; Palmer & Short, 2010). It is argued here that this approach does not take into account the complexity, uncertainty and change articulated by the CHN, midwife and women participants. This indicates how the concept of collaboration functions to obscure complexities that are not readily addressed. To illustrate this point further, an overview of the different interests in the relevant policy systems is addressed below.

8.3 CONVERGING AND COMPETING INTERESTS IN HEALTHCARE

Social concerns are projected into the public domain dependent upon the power, financial resources and media-literacy of different stakeholders (Alaszewski & Brown, 2012). That there are different interests underpins the importance of a constructionist approach to policy analysis that acknowledges the ‘claims-making’ process around conflicting interpretations of problems (Alaszewski & Brown, 2012, p. 150). Interest groups work hard to convey the notion of shared problems using the edict of collaboration to portray the need to ‘work as one’ despite contradictions. For example, the concept of collaboration was raised under the purview of system reform driven by problems and system faults. Alford (1975) argued how healthcare reform calls for coordination and integration of health systems in response to periodic crises. This reignites the ongoing struggle between interest groups that underpins different interpretations of problems. As Alford explains:

> ...health care institutions, whether described as "fragmented" or as "pluralistic" must be understood in terms of a continuing struggle between major structural interests operating within the context of a market society – "professional monopolists" controlling the major health resources, "corporate rationalizers" challenging their power, and the community population seeking better health care via the actions of equal-health advocates." (1975, p. xiv)

Federal Governments claim authority positions as financial managers or "choice architects" (National Health and Hospitals Reform Commission, 2009, p. 73) and, as advocates for the vulnerable, situate collaboration as the key action (National Preventive Health Taskforce, 2009). Working together is justified by highlighting the limited health dollar and the long list of health concerns and interests falling under government responsibility. The following text reflects how financial concerns are the imperative for reform:

> Without National Health Reform, state and territory government budgets would be overwhelmed by their rising health spending obligations: projections show that by 2045-46, health spending alone would be more than all revenue collected by state and local governments. (Department of Health and Ageing, 2011, p. 1)

This legitimated the Federal Government role as national arbiter of rationing and justified action to exert influence over other interests such as state/territory governments and individuals. The function of policy in the following excerpt demonstrates how a dialogue with the public is constructed so that problems are adopted as individual issues. This in turn reinforces the government position while calling for unified action:

> ...we want to encourage you to think about how *you* and *your* family, *your* community, *your* general practice, *your* hospital, *your* community health service, *your* workplace, *your* private health insurer, *your* university (and so on) can take actions to build a healthier future for all Australians. (National Health and Hospitals Reform Commission, 2009, p. 73)

The language of policies also functions to frame a position that gives support to unilateral action. This is achieved by constructing government action as fiscally responsible. Unilateral action is defended in terms of a crisis that demands immediate reform as will be recognised by the whole healthcare community as demonstrated here:

> This *Blueprint for better healthcare in Queensland* is the action-plan that will move the Queensland healthcare system from the first phase of repair to lasting recovery. It will transform a struggling healthcare system that fell too far behind into a model for productivity, care and efficiency to meet and surpass national benchmarks. The blueprint includes a long list of changes that will be instantly recognised by patients, local communities, doctors, nurses and healthcare workers. (Queensland Health, 2013, p. 4)

Financial management is an underlying factor in government policy and it is here that collaboration enters the agenda. The assumption is that collaboration allows systems to be less complicated and more accessible and yet approaches to collaboration in this way depict a simplistic view about how systems work. Patients are depicted at the centre of plans in health systems reform through the use of terms such as choice and self-management and reference to the *Australian Charter of Healthcare Rights* (Queensland Health, 2013). The *Blueprint for Better Healthcare in Queensland* (Queensland Health, 2013) presents a view on collaboration as a process for all to engage in because values and concerns are shared. The following demonstrates how policy reduces a healthcare system to the simplistic concepts of collaboration and partnerships:

> Collaboration and partnerships allow the healthcare system to be less complicated and more accessible for Queenslanders. (Queensland Health, 2013, p. 12)

Reform is also justified where policy links health issues to economic productivity and hence the case for health promotion and prevention (National Preventive Health Taskforce, 2009). Reform that calls for working together, however, does not readily translate into shared professional and community action because health professionals and individuals do not perceive problems in the same way. The assumption underlying health promotion is that health professionals will convert government edicts into actions at the service and individual levels and individuals will alter health behaviours to prevent future problems. This involves making clear who has responsibility for what and in monitoring progress, for example, by way of hospital and community performance reports that are available to the public (Department of Health and Ageing, 2011; National Health Performance Authority, 2013).

Professional bodies demonstrate little by way of a predilection for financial concerns. Policies that reflect professional views on collaboration reveal, instead, tensions around control of two important resources: professional practice and clients (women, children and families). Nursing and midwifery policies position professions as reference points for others. This was both by process and also expressed as clearly defined roles and responsibilities. The following illustrates this point:

> In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, women-centred care. Collaborative maternity care enables women to be active participants in their care. Collaboration includes clearly defined roles and responsibilities for everyone involved in the women's care, especially for the person the woman sees as her maternity care coordinator. (National Health and Medical Research Council, 2010, p. 1)

Nursing and midwifery policies explain how scopes of practice, competencies and codes of conduct are important indicators of professional roles and identity. Here the policies functioned to articulate clear professional boundaries managed by the professions even though the concept of boundaries conflicted with women as self-determining. Professional bodies also construct collaboration and partnerships as occurring with everyone including women, children and families, other professions and other services (Australian College of Children and Young People's Nurses, 2009; National Health and Medical Research Council, 2010; New South Wales Department of Health, 2011). This positioned the nursing and midwifery professions as pivotal in making the system work. Contradictions existed, however, where professional policies sought to articulate the social significance of nurses and midwives by linking the professions to the broader society, the healthcare system and women and families. For midwifery, this reflected a desire to dissociate from a model of acute and sick care by embedding itself within a broader social context. In this situation professional policies functioned as a 'call to arms' for newcomers by clearly articulating the agenda. The following competency standards excerpt indicates this point:

> The graduate midwife practices within a women centred, primary health care framework and is committed to seeing midwifery as a public health strategy that encompasses a broad social context. The graduate midwife understands that health is a dynamic state, influenced by particular sociocultural, spiritual and politico-economic environments. The graduate midwife has an important advocacy role in protecting the rights of women, families and communities whilst respecting and supporting their right to self determination. (Nursing and Midwifery Board of Australia, 2006a, p. 1)

There are limited examples of the representation of community interests in the policy process which suggests the dominance of this realm by professions and the state. A number of the government sponsored policy documents made reference to the interests of women and families (National Health and Medical Research Council, 2010). These varied from exemplars of women involved in policy consultations, to more generic references as 'stakeholders'. Other documents focused on "key thinkers in the child protection and child wellbeing field" (The Allen Consulting Group, 2008, p. viii) and service providers rather than consultation with families. While the interests of pregnant and parenting women were articulated through organisations, some policies gave the impression of representing women's interests. The following indicates how this practice varied and at times was deemed inadequate:

> The participants appreciated the opportunity to meet and discuss the Framework, however they asked that they not be listed as having contributed to the consultations. They emphasised that more effective participation would be achieved if consumer groups had been involved from the beginning. (Australian Health Ministers' Advisory Council, 2011, p. 53)

Ongoing work to garner the interests and opinions of women about their healthcare was facilitated through regular surveys conducted with pregnant and parenting women in Queensland (Dane, et al., 2011; Prosser, et al., 2013). This information was disseminated to parents, partners, professionals, policy-makers and politicians in the hope of influencing the system and informing policy processes (Queensland Centre for Mothers and Babies, 2012).

Children were not represented directly in any of the reviewed policies although acknowledged as important social capital (Council of Australian Governments, 2009a). This justified intervention on behalf of children where, for example, families were perceived not to be fulfilling their protective role. Policies also identified the existence of disadvantaged groups of children that demanded preventive action in the early years (Council of Australian Governments, 2009a). The rationale was that some children were displaying worse health and social outcomes and so the early years were an important time to act (Australian Health Ministers' Advisory Council, 2011). This served the interests of both protecting children perceived as vulnerable and justifying regulation to prevent long term health issues that would burden the health system.

Other community issues were focused upon albeit under professional and government control. The function of policy here was to set a different agenda on collaboration. For example, the need to collaborate on “protection, promotion, support and monitoring” of breastfeeding was linked to a typology of personal health risks to women and babies and financial costs to the whole community associated with not breastfeeding (Australian Health Ministers' Conference, 2009, p. 3). In re-defining breastfeeding as a whole of community problem interests were shifted from a specific issue in a select group to a social imperative. The text around breastfeeding then moved on to social regulation (Australian Health Ministers' Conference, 2009, p. 34).

Competing interests were largely obscured in the approach to collaboration. What remained was the assumption that the collective future investment in healthcare could be achieved if everyone worked together. Policies functioned to overtly set agendas for action because the plurality of views on what were concerns could not be accommodated. To illustrate how this complexity mediated policy this argument now turns to an exploration of how policies represented the key conceptual findings of identity, knowledge and institutions addressed in the previous chapters.

8.4 POLICY AND IDENTITY PROCESSES

The concept of collaboration presumes people will work with each other to achieve outcomes and thus clear roles exist for everyone in the process. A woman’s care is distributed across disciplines and collaboration functions to bring all parts together to integrate care so the system works efficiently as explained here:

> Collaborating partners need to make joint decisions about who will be responsible for different aspects of a woman's care. This ensures an integrated plan is implemented in a way that prevents duplication of effort and fragmentation of care. (National Health and Medical Research Council, 2010, p. 19)

Yet, policies that depict collaborating partners as health professionals who make decisions undermine the saliency of women. Furthermore, there were tensions over identity in policies because the concept of collaboration was conceived as a logical and sequential process of managing professional identity. The following gives considerable agency to health professionals to determine professional scopes of practice (boundaries) and to divide up practice around skills and knowledge. Professional role boundaries are reinforced in order to make complex issues appear simple as evident below:

> An important step in establishing collaboration is for collaborating partners to acknowledge each other's scope of practice and expertise, recognising professional competencies, roles and responsibilities. The collaborating partners should identify the knowledge, skills and preferences that each brings to the practice, so that they can decide who will do what, under what circumstances. (National Health and Medical Research Council, 2010)

Government documents make assumptions that professionals work cost-effectively and flexibly with each other because clear roles and responsibilities are built around core competencies (Department of Health and Ageing, 2010, p. 12). Yet the language around core competencies was more about how these functioned to ensure standards of professional practice (Nursing and Midwifery Board of Australia, 2006a, 2006b), to conceptualise nursing performance (Grealish, 2012) and "...guide the practice of individual disciplines and articulate with broader service-based competencies." (Australian Health Ministers' Advisory Council, 2011, p. 32). The "official language of competence" (Boreham, 2004, p. 13) therefore favours individualisation of work performance and professional fragmentation over collective competence. Competencies function to reproduce boundaries and to compartmentalise care.

What was missing in policy was any explanation of how scopes of practice could function to integrate care. There was reference to adherence to scopes of practice and to how systems required health professionals to be used to their full scope of practice (Australian Health Ministers' Advisory Council, 2010; Australian Health Ministers' Conference, 2011; Queensland Health, 2013). The tension here revolved around the need for a more flexible workforce to ensure collaboration while specialisation and professionalisation in nursing and midwifery were about maintaining clearer boundaries as a means of professional identification. Research participants pointed to the ways in which roles and responsibilities were blurred because of knowledge plurality, system gaps and individual interpretations of roles. Indeed, roles and responsibilities such as scopes of practice were broadly defined in policy to reflect the need for flexibility (Nursing and Midwifery Board of Australia, 2006a, 2008b). Individual action therefore was contingent upon individual interpretations of roles and responsibilities.

The Nursing and Midwifery Board of Australia (2007) differentiates between scope of practice of the profession and that of an individual nurse or midwife. The relationship between scope of practice and roles is thus ambiguous because factors such as context of practice; consumer health needs; competence, education and qualifications of individual practitioners; and service policies, quality and risk frameworks and organisational culture (Nursing and Midwifery Board of Australia, 2007) make this an entirely arbitrary process. Other authors agree that individual nurses continuously negotiate and adjust their scope of practice (Lillibridge, et al., 2000). Yet there was no imperative for individuals to negotiate a process that would resemble collaboration. Boreham (2002) argues that, in the UK, the somewhat ambiguous concept of ‘collaborative practice’ has been applied in healthcare policy to articulate how different health professionals can work together in virtually interchangeable roles. The vision of freedom to determine own scopes of practice and support flexible working to create seamless care for patients has not been realised because professions have merely shifted the definitions of boundaries through control over knowledge as a lever in status group conflict (Boreham, 2002).

Decision-making frameworks and competencies were posed as strategies whereby collaboration would be transparent and risk free. For example, professional documents constructed a hierarchy of responsibility around levels of care, capability, consultation and referral through frameworks that clearly articulate the role relationships between stakeholders (Australian College of Midwives, 2013; Australian Health Ministers' Advisory Council, 2010). The concerns were for safety and risk management but also nationally consistent role delineation. The following explains how gaps in collaboration were addressed. What is significant here is the explicit acknowledgement that the nature of collaboration was largely unknown. It was also assumed that an evidence-based framework, where applied, would function to reinforce the boundaries of one’s own and others’ practice:

> ...there was very little guidance available for midwives and doctors who wanted an evidence-based framework for collaboration in the care of individual women. Specifically, there was no single, nationally consistent and evidence-based tool to assist midwives to make decisions about when to discuss care and/or consult with other midwives or to refer a woman’s care to a suitably qualified health practitioner. This represented a significant barrier to the successful establishment of midwifery services, in which midwives are the primary care givers, offering women continuity of midwifery care in collaboration with other healthcare providers. These guidelines were first developed to address the gap and the revised editions continue to meet the same need. (Australian College of Midwives, 2013, pp. 2-3)

Evidence from the participants and other works, however, suggests that in reality the application of frameworks is problematic. For example, where nurses have engaged in negotiating boundaries of practice to meet the needs of patients this has been labelled as risk taking and justifies an appeal to scopes of practice to “stabilise professional boundaries” and manage professional risks (Lillibridge, et al., 2000, p. 35). Processes that sought to simplify decision-making and role interactions did not reflect care as highly differentiated and complex.

Mixed views existed on whether articulating roles and responsibilities served the interests more so of women and families or the professions. Language was important because there were differences in meanings and underlying assumptions about the roles of women, CHNs and midwives in collaboration. The following indicated one position on the role of individual women in their care:

> Woman-centred care is focused on the women’s unique needs, expectations and aspirations, rather than the needs of institutions or maternity service

> professionals. This type of care recognises the woman’s right to self determination in terms of choice, control and continuity of care. (National Health and Medical Research Council, 2010, p. 14)

Dialogue around choice co-exists with talk of collaboration as integrated professional decision-making. The language of consumerism was applied to imply a power shift through references such as this:

> Empowering consumers to make fully informed decisions is an important element of this shifting power balance between consumer and clinicians. (National Health and Hospitals Reform Commission, 2009, p. 124)

The idea of patients as powerful consumers would mean attributing authority to them by denying that other forms of authority were operating (Keat, Whiteley, & Abercrombie, 1994). Indeed, the ways in which the care relationship between women, CHNs and midwives was conceived in policy suggested a tension in authority attribution. This is because the shift in responsibility or ‘managed consumerism’ in health is constructed through a discourse that serves the interest of governments in managing scarce health resources rather than enhancing patient choice and self-determination (Bury & Taylor, 2008). In addition, policy documents that positioned women as the centre of care did not indicate how this might be negotiated (Australian Health Ministers' Conference, 2011; National Health and Medical Research Council, 2010). The following illustrates how the public was informed about issues and decisions made by health services, described as community empowerment and ownership of the healthcare system:

> Keep the public informed about key HHS issues and decisions to enable community ownership of our health system. (Metro North Hospital and Health Service, 2013, p. 9)

Positioning the child at the centre of the system (Council of Australian Governments, 2009a) and depicting services as family-centred (Children's Health Queensland Hospital and Health Service, 2013), or child-focused (Council of Australian Governments, 2009b), or even combinations of child-centred and family-focused (Australian Research Alliance for Children and Youth, 2010), supported the notion that individuals were active in their care. Without processes that ensured a shift in authority, the default position was to focus on individuals as objects of negotiated care that professionals dominated. For example, parents needed guidance in their parental role (Australian Health Ministers' Advisory Council, 2011) and women at the centre of decision-making were positioned within a context of professionally managed responsibility (Australian Health Ministers' Advisory Council, 2010). Language about working ‘with’ rather than ‘on’ families (The Allen Consulting Group, 2008) further demonstrated the multiplicity of positions on roles and responsibilities in care relationships that gave the appearance of collaboration where it was assumed that professionals would be in control. Similarly, in this research, references to ‘teamwork’ were made whereby CHNs, midwives and women exemplified the expert team as professionally managed. This appeared to be accepted as unproblematic despite language of partnerships in care. The examples above indicate how policy documents used language to legitimate boundaries while sanctioning fluid processes around identity.

Language also defined professional practice in ways that indicated territories of practice were less negotiable and not shared. For example, postnatal care was defined as midwifery postnatal care although antenatal care in the same document was not defined as midwifery antenatal care (Australian Health Ministers' Conference, 2011). Furthermore, the early postnatal period was framed in terms of the overlapping roles of midwives, CHNs and GPs indicating a tension rather than a shared role that could be negotiated given the needs of women (Australian Health Ministers' Advisory Council, 2011). A number of women in the research described feeling compelled to work with both community and hospital services in the care continuum because the services were seen as separate and the woman’s role was to fit in with both systems. Other studies have indicated how child and family health nurses and midwives across the care continuum see services as separate and lacking in vision on how services can coexist (Homer, Henry, et al., 2009).

There was a shifting position on roles and relationships in policy documents. Nonetheless the prevailing emphasis was on professionally controlled collaboration and how mechanisms were needed to sustain collaborative arrangements for women. The underlying assumption was that if roles and responsibilities were clearly defined the system would work well. The multiple ways identity was represented in policies, however, revealed an enduringly simplistic view of the concept of collaboration that was open to individual interpretation and was therefore an arbitrary process dependent upon dominant interests. Policy dialogues struggled to position women as salient identities in healthcare which is consistent with the findings in this research. The following section moves on to explore policy through the concept of a knowledge order.

8.5 POLICY AND THE KNOWLEDGE PROCESS

The function of policy was to construct knowledge as organised and shared and thus the basis for collaboration. Professionals assumed greater control over knowledge because of a predilection about the dominance of professional knowledge. For example, the reference to provision of ‘objective’ information below is positioned as a necessary pre-requisite of informed decision-making and choice for women:

> This plan identifies communication strategies to facilitate women’s awareness of the available information and their options for care. The provision of objective information related to services, and access to it, enables women and their families to make informed choices about their maternity care. (Australian Health Ministers' Conference, 2011, p. 27)

Other references to a hierarchy of knowledge depicted governments as controlling this process to ensure the correct information was available so that people would make the best choices and decisions (National Preventive Health Taskforce, 2009). This form of information would be based on best evidence, agreed to and endorsed by professional and consumer groups (National Health and Medical Research Council, 2010). The message for health professionals is that types of information influence decisions and choices. There were indications in the research that women understood that information provided to them carried certain imperatives. The government position was that decision-making in healthcare could be influenced to promote health and that professionals had a role in this process:

> Government action is critical to ensuring that people are well informed and can make the best decisions for their health and wellbeing, including choices about optimal health-promoting behaviours. (National Preventive Health Taskforce, 2009, p. 56)

Yet, what was significant knowledge was unclear. For example, women would exercise self-determination, autonomy and control by basing decisions on best evidence (National Health and Medical Research Council, 2010) while what constituted best evidence was not defined. Professionals were considered to be best positioned to influence decisions. The women participants reported being overwhelmed with information which contributed to uncertainty in decision-making and sustained dependency on professionals.

Policies functioned to give the appearance of knowledge as transparent and readily shared between professionals and families. For example, four “golden rules” for information sharing were referred to when working with families (The Allen Consulting Group, 2010, p. 41). The rules included being open and honest in communication; using informed consent to share personal information; having necessary, proportionate, relevant, accurate, timely and secure information; and finally recording decisions and reasons about information sharing (The Allen Consulting Group, 2010). This was not how women, CHNs and midwives described information sharing. Rather women participants did not share information for fear of stigma and conflict, or where they did not know health professionals well enough. Midwives and CHNs shared information selectively with women in situations of child protection or to protect women from difficult situations. Therefore conditions were placed on knowledge sharing both professionally and personally that were more complex than policies indicated.

There were also shifting positions on knowledge sharing in policy. Assertions were made that people would become more involved in their care when knowledge was shared. For example, people would be more involved in decision-making by using personal health records as a means of controlling personal information (Australian Health Ministers' Conference, 2011; Department of Health and Ageing, 2010; National Health and Hospitals Reform Commission, 2009; National Health and Medical Research Council, 2010). The following explains this position:

> Giving people better access to their own health information through a person-controlled electronic health record is also essential to promoting consumer participation, and supporting self-management and informed decision-making. (National Health and Hospitals Reform Commission, 2009, p. 8)

Personal health records were also described as a means to improve continuity of care and communication, suggesting that transparency and shared knowledge supported the notion of patient-centred care (Department of Health and Ageing, 2010; National Health and Hospitals Reform Commission, 2009; National Health and Medical Research Council, 2010). Yet it has been reported elsewhere that women do not see health records as either improving communication with professionals or facilitating a sense of control or shared responsibility in care (Patterson & Logan-Sinclair, 2003). Further, constraints on transparency and accuracy of information sharing in the postnatal discharge process, exist because the majority of women do not have an opportunity to understand what information is transferred between services or to assess the accuracy of the information (Jenkinson, et al., 2013). While the women participants expected that professionals would share information, shared records could serve other functions. For example, policy depicted how shared records could be used to monitor decisions made by other professionals. This was less about engendering control for women and more about health professional interests as implied here:

> Woman-held records can help improve continuity of care by the consistent tracking of conversations and decisions during a woman's maternity care, and facilitate transparency and accountability. (National Health and Medical Research Council, 2010, p. 44)

Information sharing and data linkage was continually referred to as important for health professional work. Professional dialogue focuses on the ethical and professional conditions of information sharing (Nursing and Midwifery Board of Australia, 2008a, 2008b). Where CHNs, midwives and women referred to personal, philosophical, legislative and professional barriers to information sharing, policies challenged the legitimacy of the claims (The Allen Consulting Group, 2008). The professional dominance of knowledge processes provides the basis on which collaboration is drawn into the conversation:

> Limited mechanisms for sharing information and linking data about children and families across professions, services and government agencies hinders effective communication and collaboration. (Australian Health Ministers' Advisory Council, 2011, p. 39)

Tensions around knowledge processes, as described by research participants, pointed to complex negotiations while the official policy position was that knowledge could be managed to make systems less complex. Processes for controlling knowledge, for example, included designated roles (liaison positions and multidisciplinary teams), care structures (case management approaches, policies, protocols and pathways), models of care (populations and public health models), language systems (The Allen Consulting Group, 2010) and capability frameworks (Australian Health Ministers' Advisory Council, 2010, 2011; Australian Health Ministers' Conference, 2011; Australian Research Alliance for Children and Youth, 2010; National Health and Medical Research Council, 2010; The Allen Consulting Group, 2008). Yet CHNs and midwives in this research drew attention to the structural elements of the knowledge order that had to be circumvented to individualise care, to overcome selective sharing and to manage uncertainty.

Models and frameworks are common in policy as representations of consensus views, to provide direction and manage uncertainty (Queensland Health, 2008) and to act as organising frames for integrating and coordinating services thereby projected as collaborative work (Australian Health Ministers' Advisory Council, 2011; The Allen Consulting Group, 2008). It is argued that diagrammatic depictions of situations assists people to ground what exists as ambiguous into meaningful joint actions (Rushmer & Pallis, 2002). Models and frameworks, however, misrepresent interactional processes. Policies suggested how the needs of patients might be identified using assessment frameworks and to establish common goals as the basis for working with each other (Australian Health Ministers' Advisory Council, 2011; National Health and Medical Research Council, 2010; New South Wales Department of Health, 2011). Indeed, assessments were important to CHN and midwife participants in the delivery of care. Processes such as this sustain professional control over knowledge because professional assessment justifies the positioning of women and the rationing of services. The following example illustrates how a systematic approach to knowledge was depicted as collaboration:

> The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes. (Nursing and Midwifery Board of Australia, 2006b, p. 1)

The function of policy dialogue is to sell healthcare reform in ways that tap into professionally controlled knowledge processes to make systems work and to represent this as collaboration. The research participants, however, described how frameworks were continually adapted to fit the reality of situations as professionally defined and that individuals become invisible in this process. The following indicates how policy functions to represent a quite different impression of collaboration as knowledge processes controlled by governments and professionals:

> Redesign also involves ensuring that this complex array of services is well coordinated and integrated through more effective use of tools including standard assessment tools (to augment good clinic method), agreed communication systems with some built in protocols, shared understanding of care pathways and engaging the whole health care team, reforms to funding and embedding data systems for clinical and management purposes that promote better continuity of care and multidisciplinary collaboration across health care professionals. (National Health and Hospitals Reform Commission, 2009, p. 102)

The participant experience was that knowledge was selectively shared and did not bring the system together. Further, women did not always want to ‘fit’ the system or engage with services following assessment. In addition, the perception about what constituted significant needs and risks varied between CHNs, midwives and women. This suggests that assessment frameworks were open to individual interpretation and application. The shifting positions on knowledge sharing as collaboration illustrate how policy functions to shape preferred definitions of situations. The argument here is that significant disjunctions in policy positions on knowledge reflected the contradictions and paradoxes surrounding the concept of collaboration. The following section takes this point further to explore how institutions were represented in policy.

8.6 THE POLITICS OF HEALTHCARE INSTITUTIONS

There was inconsistency in the attribution of responsibility among different interests in policies. Government policy demonstrated a preoccupation with a hierarchy that clearly identified the levels of responsibility, most often defined on the grounds of governance and financial management. This process of attribution was not negotiated. For example, the justification for a *Healthy Australia Accord* made reference to shared responsibility between interests while the responsibilities of individual Federal, State and Territory governments would be clear on financial matters (National Health and Hospitals Reform Commission, 2009). The sharpened boundaries of responsibility and accountability justified reform:

> As far as possible, governments should be directly responsible and accountable for the effects funding decisions have on programs. Conversely, the fiscal implication of policies and program management decisions should rest with the government making the decisions. This is not the case for health services in Australia at the moment. (National Health and Hospitals Reform Commission, 2009, p. 146)

This approach was found in other government and professional policy documents that presented formal agreements, guidelines, decision frameworks and pathways as ways to make clear responsibilities that would ensure safe care and provide performance measures (Australian College of Midwives, 2013; Australian Health Ministers' Advisory Council, 2010; Australian Health Ministers' Conference, 2009; Council of Australian Governments, 2011). Formalised agreements, as collaboration, would integrate services and minimise fragmentation and duplication of services (Council of Australian Governments, 2011; Queensland Health, 2013). National agreements would represent shared understanding, responsibility and commitment (Council of Australian Governments, 2009b).

Agreements provide incentives and benefits for collaborators while also acting as a form of control in holding others to account for actions. Rather, as has been argued in the earlier analytical chapters, agreements and assessments can also be applied to depict situations more favourably, shape the behaviours of others and shift responsibility. Research into government funded agreements and incentives for teamwork and communication, such as the Medicare funded 'Team Care Arrangements' for chronic disease management (The Department of Health, 2013) provide the structures and opportunities for multidisciplinary team-based care. Yet, research suggests improved communication and teamwork between health professionals does not necessarily occur (Harris, et al., 2010). Further, arrangements that are defined as collaborative such as the *National Health Determination 2010* (Commonwealth of Australia, 2010) dictate the 'collaborative arrangements' required between eligible midwives and medical practitioners in order for the former to access medical and pharmaceutical benefits schemes. Medical interests see the arrangements as "in the best interests of patients and all members of the collaborating team" (Australian Medical Association, 2010, p. 4). Others see this policy as the antithesis of collaboration because it places unnecessary conditions on professional practice and access to services that privileges professional groups such as medical practitioners and obstetricians and functions to maintain the hierarchy of responsibility and authority in healthcare (Heatley & Kruske, 2011; Lane, 2012a, 2012b).

There were situations where single points of responsibility such as liaison and discharge nurses were identified and hence it was argued that systems such as knowledge flow would improve because there would be one role involved (The Allen Consulting Group, 2008). The experience of the CHNs and midwives, however, was that single point accountability undermined collaboration because those in discharge and liaison roles assumed responsibility for gaps within the care continuum. Yet responsibility shifted to shared positions on specific issues such as child protection, whereby policies urged shared professional accountability for vulnerable children (The Allen Consulting Group, 2008). At other times parents were deemed obligated or children were represented as the responsibility of all thereby ensuring that everyone had a role in child safety and wellbeing (Council of Australian Governments, 2009b; The Allen Consulting Group, 2008). This functioned to counter risk aversion and to delegate responsibility in such a way that assumed collaboration:

> ...building shared responsibility and overcoming a culture of risk aversion will require the development of shared responsibility for protecting children using integrated governance....Integrated governance is supported by structures and processes that encourage collaboration. (The Allen Consulting Group, 2008, p. xii)

Similarly, joint decisions would not involve blurred responsibilities, but rather more sharpened boundaries of responsibility. The following indicates this position on responsibility and decision-making:

> When key decisions are made jointly by collaborating professionals, there should be shared responsibility for these decisions. Clearly documenting details of all referrals, consultation and decisions can help avoid any blurring of responsibilities. (National Health and Medical Research Council, 2010, p. 18)

Preventive care was contingent upon regular risk assessments and data (Department of Health and Ageing, 2010) although it was acknowledged that individuals and health professionals had different views about what constituted risks

(Department of Health and Ageing, 2009; National Health and Medical Research Council, 2010). Other documents projected a fluid idea of risk where women could have “normal risk factors”, categorised as “normal risk women” (Australian Health Ministers' Conference, 2011, p. 30) or have “self-rated pregnancy risk” (Department of Health and Ageing, 2009, p. 37). Shifting positions on risk and responsibility functioned to professionally shape needs as participants in this research indicated. The following illustrates the tension between personally and professionally managed risk:

> Successful collaboration depends on communication, consultation and joint decision-making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe health care. (Nursing and Midwifery Board of Australia, 2007, p. 16)

The NHMRC also acknowledged the potential that risk would contribute to fear so that a state of being “frozen by risk” was perpetuated which reflected a risk averse rather than supportive culture (National Health and Medical Research Council, 2010; The Allen Consulting Group, 2008, p. 30). This was despite references to how risk assessment was potentially flawed in child safety work in not identifying those in need and not predicting the risks to safety and wellbeing of children (The Allen Consulting Group, 2008). Risk permeated nursing and midwifery policy dialogues (Australian Health Ministers' Advisory Council, 2011; Australian Health Ministers' Conference, 2011; New South Wales Department of Health, 2011). This suggests how the construction of risk functions to sustain legitimate professional identity, maintain professional control and justify the role of government as system regulators. The language of collaboration is central to the treatment of risk in policy documents.

Policy positions have advocated for a shift in this process whereby shared assessment processes would focus on identification of need rather than risk, for example, the “Common Approach” represents a collaborative engagement with parents around knowledge and decision-making (Australian Research Alliance for Children and Youth, 2010, p. v). Yet, in recalling how needs were reconstructed by CHNs and midwives for different purposes in this research this policy imperative may have limited effect in shaping power sharing arrangements in clinical situations. This demonstrates how policy functions to reshape professional responsibility for health concerns using language around collaboration in ways that belie the real world of healthcare practices. For example, the case is moot on child protection:

> If Australia is to move to a more preventive focus for protecting children we need to move away from the context of 'child protection' which is seen as the domain of statutory authorities to a focus on ' protecting children' which is understood as being everyone's responsibility. While the nomenclature is a small point, the implications are huge. Moving to prevention requires *all* systems that provide services to children and families to be part of the *collaborative system* for protecting children. (The Allen Consulting Group, 2008, p. 15)

Participants in the research indicated difficulties in engaging families in shared responsibility because of differing priorities where, for example, CHNs and midwives translated need as risk and identified women who did not wish to engage with services as resistant and deviant. This demonstrates how policies shape professional practice in ways that give conflicting messages about collaboration where political imperatives around assessment and risk become obstacles to working in partnership.

In contrast to shared responsibility, policies also drew attention to individual responsibility for health, or the nurturing of self-management of health (National Health and Hospitals Reform Commission, 2009). The assumption was that when people knew how to manage their own health this would increase participation in self-health care and provide the basis for a partnership with health professionals (Department of Health and Ageing, 2010). The following policy extract illustrates this point:

> ...good health is not something that is simply 'done' to us through our interactions with the health system. We must be active participants in our own good health, working in partnership with our health professionals, our carers and families. But this has to occur within the context of our social and economic circumstances and the communities in which we live. (National Health and Hospitals Reform Commission, 2009, p. 96)

Indeed, policies positioned women as active and in control of their own care (National Health and Medical Research Council, 2010) although this research found that perception of need differed and therefore actions were open to interpretation.

Conflicting interpretations construct boundaries rather than shared zones for negotiation.

There were a number of positions on individual responsibility attribution in policies. The first was that governments would shift responsibility for health under only some conditions. Having people active in their own health, for example, suits the system if this shifts costs back to individuals and away from the public purse. Another view is that people cannot be trusted to make the right decisions for their health and this may be costlier for the system in the long run. In this case, government reconstructs collaboration as a staged approach to responsibility called “responsive regulation” (National Preventive Health Taskforce, 2009, p. 57). The staged approach creates the notion of collaboration, that is, responsibility is shared within limits. This means healthy choices and market forces can be manipulated by governments as indicated here:

> This approach respects the fact that, when confronted with good evidence of the negative externalities arising from particular practices, many players in the marketplace want to do the right thing. Responsive regulation allows for voluntary adjustments and the development of creative solutions through government, industry and consumer partnerships, but actions are clearly seen to occur within a framework of regular review and the introduction of sanctions should inappropriate behaviours persist. (National Preventive Health Taskforce, 2009, pp. 39,57)

Regulation works on the idea that people want to do the right thing if in possession of the right information and assumes that the process involves a choice of options of various repute (National Preventive Health Taskforce, 2009). It is simplistic to assume that all share equally in options and choices. The paradox of the social determinants of health, whereby those with the least resources for health suffer the greater burden of ill health and disease, directly challenges personal responsibility as an effective model for preventive health (World Health Organisation, 2003). This is further difficult to justify in the case of those without a voice or choice such as infants and young children who are not capable of self-care (Peter, et al., 2007) or the socially disadvantaged who have limited resources for negotiation of choice (Ebert, et al., 2013). Snelling (2012) argues that the concept of responsibility as it manifests in policy has a social function to provide a framework for helping people to understand their obligations for health that conflicts with the professional ideals of personal autonomy. Shifting from collective to individual responsibility for health is, more obviously, a means for governments to mitigate rising healthcare costs (Michailakis & Schirmer, 2010). Thus, the contradiction appears where official rhetoric is framed around shared responsibility while professional systems continue to adopt approaches that focus on defining needs as risks in ways that sustain the demand for professional services. While collaboration may be proffered as the solution, regulation is sustained as the default option because responsibility is ultimately professionally shaped. Collaboration and partnerships with patients and healthcare consumerism is applied throughout health policy and conceals the complexities of health and social issues whereby responsibility attribution is simplistically represented (Carnwell & Carson, 2005; Wikler, 2002).

Policies referred to how services were “uniquely placed” to support families and identify health issues (Australian Health Ministers' Advisory Council, 2011, p. 4) while communities needed to be mobilised to influence individual behaviours and governments needed to create a framework to manage and monitor the situation. The assumption is that individuals and communities act and think as one as influenced by professionals. The research does not support this view because individual behaviours differed and were influenced by many factors. Furthermore, the policy process sustains health professionals as most knowledgeable and therefore responsible. The flexibility in the use of the term responsibility in policy, however, pointed to the complexities around this issue. The complexities elude the system approach.

8.7 CONCLUSION

This chapter has argued that policy documents reflect a shifting and ambiguous position on the concept of collaboration. There were conflicting ideological positions that suggested the concept carried multiple functions. The ambiguity conflicts with how a systems approach to policy works. First, policies revealed how divergent interests in the political field underpin different interpretations of the concept of collaboration. Second, the concept of collaboration is consistently represented as something shared while policies sustain an understanding of collaboration as a predominantly professional concern. Third, the complexity of knowledge processes referred to by research participants was simplified in the policy positions explored in the chapter. More broadly, where systems depict responsibilities as shared, it is clear that responsibility shifts between professions, organisations, the individual and communities depending upon the dominant interest being represented. This suggests that collaboration is depicted as something that exists out there in the social world or can be created within professional and political systems. The analysis demonstrated an array of positions on collaboration. While collaboration is interpreted simplistically using a systems approach it is clear that the concept is utilised by different interests to obscure the complexities of social relations including how power relations operate in healthcare. While there were areas of convergence on the concept of collaboration between policy and practice, contradictions were obscured and ambiguity sustained. Society does not exist only at the systemic level because, as argued, there is a subjective aspect to all that is social that acknowledges the complexity of human interaction. The following chapter provides some final reflections on the findings of this research and some commentary on the implications of this work.

Chapter 9: The Social Function of Collaboration

9.1 INTRODUCTION

This chapter draws together the key theoretical understandings generated in this research. First, the objectives of the study are revisited along with the theoretical position that informed the exploration of the concept of collaboration. Second, the assumptions drawn from the published literature are reviewed, followed by the key theoretical understandings on collaboration generated in the analysis around identity, knowledge, institutions and policy documents. The overarching theoretical argument is that the concept of collaboration fulfils an important social function in healthcare. As such, a critical exploration beyond the veneer of consensus in interactions challenges the concept of collaboration as it is applied in the research context.

The veneer of consensus, about which Goffman (1967) wrote, sums up how interactions proceed even though differing meanings co-exist in situations. In applying this concept to the research situation we see that interactions in healthcare proceed based not on *what exists* but rather on *whose claims* concerning *what issues* are temporarily honoured in situations (Goffman, 1967). The language of collaboration conceals much of the complexity that exits in healthcare, including how power relations are sustained where an overall impression of shared power meets potentially rival individual, professional, organisational and political needs. Where rival definitions and divergent interests are concealed, such as in the application of the concept of collaboration, situations can be handled so that shared knowledge, values, power, decision-making and goals are not a necessity for interaction. Further, the concept of collaboration, by way of ambiguity, conceals how power and authority exist without full acknowledgement of the part these factors play in situations. Ambiguity allows for the coexistence of competing positions and this sustains an impression of negotiated decision making. Further, by way of ambiguity concepts take on multiple meanings which allow predominant views about social situations to be reproduced and reconfigured for specific purposes.

The social function of collaboration rests with these two points; the concealment of complexity and the promulgation of ambiguity. This chapter will explore further the key theoretical ideas underpinning collaboration and conclude by engaging in some final reflections and comments on this research work. First, the chapter will revisit the objectives of the research, the assumptions drawn from current literature and the theoretical position adopted throughout the research process.

9.2 REVISITING OBJECTIVES

This research began with the aim of exploring in a different way the concept of collaboration through a range of perspectives in one healthcare context. This understanding was further informed by an exploration of a sample of key policy documents. The two research questions that shaped this inquiry were:

How do midwives, CHNs and women construct the concept of collaboration within the care continuum between a maternity and a community child health setting?

How do policy documents construct the concept of collaboration?

As previously argued the concept of collaboration is complex and ambiguous and there are diverse views on how and for what purposes this concept is applied and what meaning it carries. Before exploring this further, a return to assumptions underlying collaboration drawn from the literature and a revisiting of the philosophical position of the research will ground the discussion.

9.3 ASSUMPTIONS ON COLLABORATION FROM THE LITERATURE

The concept of collaboration has traditionally been associated with an ongoing tension between dominant interests in healthcare ("Schism or collaboration?," 1947). How roles and responsibilities function as collaborative is unclear because there are varying opinions on professional and personal boundaries and the extent to which these are and must be shared or discrete. Assumptions underpinning the concept of collaboration give the impression that power, responsibility, decision-making and objectives are essentially shared (Petri, 2010). That consensus is reached through communication and negotiation is also assumed. Terms such as partnerships coexist with the language of collaboration which sustains the idea of something shared and drawn together. Further, cooperation, coordination, collaboration, partnerships and integration are conceived as existing on a continuum of healthcare relations.

Literature reviews and concept analyses have sought to reduce collaboration to key constituent parts including structural and procedural factors and key antecedents, attributes and consequences to the concept (DÁmour, et al., 2005; Henneman, et al., 1995; Petri, 2010). Other approaches position collaboration as external to organisations, within organisations and within interpersonal relations. The result is that collaboration is both something that exists ‘out there’ in the world, removed from specific situations, and something unique to individuals. Arguments are thereby posed that collaboration is, on the one hand, for governments, professions and organisations to create and, on the other hand, for individuals to negotiate. Such arguments, however, imply that it is ‘hard work’ where there is a need to be ‘ready’ to collaborate and by implication not something innate to social exchange. From either position collaboration is depicted as planned and strategic and not appearing in an ad hoc way through interaction.

Although the use of the concept purports that there is much to be gained from working collaboratively; who gains and how is unclear. It is assumed that something is to be gained by all because of shared goals and yet competing interests and dominant views on goals and outcomes underpin interactions. Studies on the concept of collaboration around CHNs, midwives and women working together reflect shifting positions on professions and healthcare consumers as the focus of concern (Heatley & Kruske, 2011; Lane, 2012b; Orchard, 2010; Schmied, et al., 2010).

Despite the disparate constructions a consistent thread is that collaboration is the responsibility of someone or something, the individual or the system, and there is an underpinning purpose. The following section revisits the theoretical tenets adopted throughout the research that provided the tools for a critical exploration of meanings surrounding collaboration.

9.4 SITUATING THE RESEARCH

The research was situated within a critical theoretical framework anchored by the philosophical position of constructionism. This perspective on knowledge and meaning assumes that there is always a subjective and individual aspect to everything that is social. Herein lay the basis for a theoretical exploration of the concept of collaboration as neither discretely individual nor social. This position shifted the focus of inquiry to the social processes that occur as people interact and define their worlds. This is because a critical engagement involves questions of what, how and why in exploring socially complex situations and situates understanding within broader historical and social conditions. The approach was to peel back the descriptive veneer, or the immediately obvious, to look in a more critical way at how concepts serve social and political interests. The generated theoretical understandings of collaboration constituted three levels of social process; identity, knowledge and institutions. In the following the conceptual findings are further explored and situated within a broader social context.

9.4.1 Identity: Consumers and the Professions

In Chapter Five, the interactional dimensions of collaboration were explored. Identity importantly has two parts, social and self identity, that suggests people are available in interactions as resources for exchange. It was argued that particular identities were salient in interactions depending upon three conditions. The first concerned how being known and invoking a desired identity depended on access to and use of a legitimate field of knowledge. Knowledge defined and positioned people as authentic and as such health professionals dominated interactions in order to sustain a professional salient identity. Despite this, identity was also inherently precarious. This is because professional knowledge is always contested and so professions need to continuously negotiate knowledge to secure a dominant position, to sustain and reproduce boundaries and thus to impose professional definitions on situations. Professions are able to exert themselves as a dominant force as reflected in the research context because of claims to discrete knowledge and enactment of privileged functions on the basis of this knowledge. Healthcare consumers, however, struggle to have personal knowledge legitimated even though positioned by professionals as the experts on their affairs, as with women in this research. Woman-centred care, being with women and partnerships in care all seek to situate healthcare consumers in a dominant position.

The second condition was how the strategic positioning of people reinforced certain definitions of situations. People were defined by ownership of socially significant resources which was important to sustain desired positions. For example, it was argued that control of women and babies by health professionals sustained professional identity. The final condition concerned how expectations operated socially and subjectively in positioning people and thereby influenced identity salience. It was here that the concept of collaboration functioned to conceal how power relations privileged professionals despite language around care that was focused on partnership between women and a client-focused healthcare system. As such, Chapter Five argued that the concept of collaboration functioned to conceal the ongoing struggle for professional dominance that underpinned interactions in the context. Collaboration thereby functioned to obscure the complexities of interactions and the dominant interests of professions.

Barriers to nursing and midwifery practice are represented as lack of visibility and recognition within a complex system (Biro, 2011; Brodie, 2002). It is not surprising therefore that within nursing and midwifery work, there is a professional preoccupation with boundary maintenance. Reference was made in the research to the invisible nature of much of nursing and midwifery work. The process of ensuring visibility means professions continually engage in ways to redefine practice. An example is the proposal that midwifery be redefined as primary health care and public health strategies (Biro, 2011; Nursing and Midwifery Board of Australia, 2006a). Although such strategies are important they conflict with the ideal of clients at the centre of care and individual women as experts and resourceful healthcare consumers. The following reflects how this redefinition process can be understood as an endeavour to lay claim to a professional space that locates roles within a broader context:

> It can be a challenge for midwives to go beyond thinking about the individual women and babies they see on a daily basis. As important as it is to think about the care of individuals on a day to day practice level, it can be self-limiting. Midwives need to view their care and the outcomes of it in the context of the broader population of childbearing women. (Biro, 2011, p. 21)

A lack of visibility associated status is the impetus for professions to seek different ways to expand their influence. This process occurs in reference to other professional identities as well as healthcare users. As Fournier (2000) asserts, professional boundaries are ever malleable and expandable and are rearticulated not eroded by the market. Influences such as healthcare reform change the ways that professions are legitimised so that professions need to continually manage and defend boundaries and seek out new ways to define situations and sustain desired positions. Midwives and CHNs are better equipped than healthcare consumers to position themselves in this way because the resources for identity salience, including the knowledge hierarchy, an ability to manipulate resources and control expectations are disproportionately available to healthcare professions. The labour of division, of which Fournier (2000) wrote, refers to the constant work that professionals engage in to maintain and re-create boundaries whilst simultaneously sustaining the impression of working as one with the healthcare consumer.

Individualisation of professional practice whereby professions re-invent themselves to maintain dominant positions reflects how identity is an ongoing construction in response to a changing social context. Professions compete with each other and the consumer through expanding knowledge domains. The impetus to reconstruct professional boundaries also comes from within professional systems. Individualisation of competence and performance and a focus on profession specific competence and knowledge increases the capacity of professions to respond to perceived threats but does not allow teams to address issues collectively that enable collective competence (Boreham, 2004). Boreham argues for competence to be extended to progress a sense within organisations of working together and of inter-dependency among group members. This research, however, has demonstrated that professions define and position each other through knowledge claims and thereby reinforce the existence of discrete roles. At other times knowledge domains, that had shared elements, operated by way of implicit rules about how and when knowledge could be used. Such is the social context within which the language of collaboration has been cast. The concept functions to obscure the complexities and conceal contradictions.

9.4.2 The Knowledge Order and the Concept of Collaboration

Chapter Six explored the function of knowledge within the interactions between CHNs, midwives and women. Knowledge was fragmented and incomplete despite an impression of order. Furthermore, boundaries around professional knowledge were constructed in such a way to maintain dominant definitions of situations which, in turn, contributed to the incomplete and tentative nature of knowledge that characterised the care continuum. The needs of women were medicalised because health professionals assumed ultimate control over the health assessment processes. This defined women in ways contrary to the discourse of shared knowledge and partnerships in practice. The notion of holistic care extends to knowledge on the physical, social and psychological aspects of people’s lives. Yet, this construct also divides up care into select domains, giving health professions greater access to and control over what can be defined as health concerns.

The chapter also explored how uncertainty around knowledge created knowledge dependencies. Where uncertainty was seen as non-normative and as a legitimate starting point in interactions, sharing power to negotiate uncertainty was reduced. A not-knowing stance has been explained as one where professionals shift from the position of expert knower to a more tentative and collaborative position working *with* rather than *for* families (Anderson, 1990; Hoskins, 2011). A not-knowing stance, however, sits uncomfortably with the idea of the expert professional and the fact that health professionals invest considerable time and effort in the accumulation and organisation of knowledge. The not-knowing stance thus represents a de-professionalisation process that threatens professional identity. Professionals engage in dialogue around evidence-based practice to reinforce the hierarchy of knowledge that subverts intuitive knowledge, experiential knowledge, lay skills and hence the wisdom of healthcare consumers. Health consumers are not empowered to bring knowledge legitimately to healthcare negotiations when relevant information is deemed objective according to predetermined relevance systems. The language of evidence-based practice situates consumers at a distance, reifies the professional knowledge gap and engenders healthcare consumers reliant on health professionals to know ultimately what is significant.

The contradiction around professionals as experts and as partners in care with consumers assumes a guise of the unproblematic within the language of teamwork, transparency and partnerships. Yet, healthcare consumers receive conflicting messages about relationships with healthcare services where, on the one hand, they are characterised as self-determined and responsible, knowledgeable experts in their own care and on the other hand are subjected to government and professional regulation of care. The need to manage expectations and demand for healthcare suggests how “managed consumerism” (Bury & Taylor, 2008, p. 215) is constructed to balance the choice and self-determination of consumers with institutional constraints. The concept of collaboration is applied to reconcile the contradictory propositions.

Healthcare systems are not structured to capture the complexity of negotiations involved in partnership practice and collaboration and in particular around knowledge exchange. Work of this type is not readily visible and nor is it rewarded in systems where quantification of work is a key predilection. There are few tangible rewards for collaborating professionally around knowledge because this is not acknowledged as ‘real work’. Furthermore, the ad hoc nature of collaborative work means situations have to be re-created over again while complex systems rely on structured knowledge processes that belie collaboration.

A final issue around knowledge pointed to the unequal sharing of information as it reinforced a dominant ideology in healthcare and challenged the notion of collaboration as shared knowledge. The selective sharing of information creates suspicions about what is known and not known which justifies covert action to continually mediate these positions. Professional issues, for example around consent and safety of staff, are used to legitimise the selective sharing of information. The concept of collaboration thus obscures a hierarchical knowledge order in healthcare and by way of ambiguity is invoked to sustain the impression of order.

9.4.3 Ideological Tensions in Healthcare

The following chapter went on to explore how institutions are assumed to represent order although this assumption is continually challenged. Collaboration contributes to order in a deliberative way although, in this research, collaboration was ad hoc and contingent work that left little ‘evidence’ of what really occurred. Systems are constructed around linear processes and neat pathways that reveal little of the reality of practice including competing views. Situations are actively reconfigured to gain support for respective interests as revealed by the research participants. The focus of the chapter then shifted to the work required to negotiate the dialectic between what exists and what is expected and thereby illustrated the ambiguities and contradictions that existed at different levels of organisations. The needs of healthcare consumers are professionally constructed and this changes the context for interactions and shared decision-making. In so doing professionals redefine client needs as professional concerns and risks. In the research professional involvement was transformed into unilateral action where decisions were imposed upon the women rather than determined with the women.

Normal life events such as pregnancy, birth and parenting are increasingly being medicalised (Conrad, 1992; Knaak, 2010; Thompson, et al., 2011). The wellbeing of women in the perinatal period has come under greater professional scrutiny through the application of assessment frameworks designed to detect early health and parenting concerns (New South Wales Department of Health, 2009). As health risks around childhood and maternal morbidity have changed, different concerns have taken hold, including social and emotional health concerns. Further, the focus on prevention has placed pregnancy, infancy and early childhood firmly on the government agenda and justified systems of surveillance. For example, processes around the prevention of child abuse and neglect shift responsibility and sustain the role of the vigilant professional. In the same way, imperatives for chronic disease prevention construct breastfeeding as a social norm and create expectations which contradict the propagated ideal of consumer choice. Prevention thereby perpetuates a risk averse culture in healthcare. This means that access to healthcare becomes focused on surveillance and support of those apportioned to vulnerable groups to the exclusion of others (Kruske, et al., 2006). Risk averse cultures also underpin the need to maintain a professional distance from healthcare consumers which presents challenges to partnerships in care and reinforces knowledge boundaries.

The conception of a healthcare journey as a client-focused complete care event is embedded in the care continuum construct. Yet, the surveillance referred to above defied shared responsibility through the care continuum particularly where clients were defined as vulnerable or at risk. The care continuum was justified in terms of professional accountability and concealed in language around the avoidance of risk. Yet professional monopoly over responsibility leaves no space for partnerships in care and responsible healthcare consumers. The function of collaboration is to conceal the contradictions and tensions on a care continuum.

Finally, the argument was posed that situations are reconfigured on an ongoing basis to serve different individual, professional and organisational interests. Ongoing tension existed as institutional needs were continually reconciled with those of CHNs, midwives and women. While ideals around partnerships in care assumed that individualised care was easy to achieve there were elements that undermined such processes. The complexity of individualised care within the care continuum is not readily captured. As a consequence much of the ad hoc work that is involved in working within systems remains invisible. Collaborative work gains little legitimacy in healthcare that is focused on standardised processes with key performance indicators and activity based funding as evidence of real work. Further, the ability to reconfigure institutions to represent different interests is always differentially available and dependent upon how the power hierarchy operates within professional systems and complex organisations. The concept of collaboration conceals complexities by implying there is a whole that negotiates freely around conflicting ideals.

9.4.4 Political and Professional Tensions in Healthcare

The political context was introduced in Chapter Eight to illustrate how policies represented the dominant interests of professions and government. Policies that adopt a systems approach to healthcare reduce complex situations to discrete parts and use the language of collaboration and integration to frame how all should work. The simplicity of this approach is challenged because society does not exist as a coherent system; rather there are competing dimensions to all situations that provide infinite complexity. A significant feature of policy-making was the assumption that different interests could be brought together within a frame of participation and consultation despite differential power relations. Furthermore, the use of external consultants in government policy-making processes sustained an impression of objectivity that belied how dominant power relations exist.

The state’s position was invariably conceived within the language of healthcare reform where collaboration was the vehicle for the rationing of health services. Health problems were constituted as collective concerns to be acted upon on the basis of economic interest. One implication was the shifting of responsibility for health to the individual albeit within a framework of overarching regulation. The concept of collaboration was symbolic of the ways in which healthcare consumers and professionals should achieve a ‘collective good’ because of assumed shared interests.

Policies also demonstrated the defining of health needs in particular ways and shifted responsibility between different levels of government and to individuals. An example was where need and risk were reconstructed to justify models of surveillance and professional control and where the financial imperative justified regulation over choice. A second example was how responsible financial management was framed as ‘empowering local communities’ to justify the exposure of public healthcare services to private sector competition, to save costs and to improve quality and performance in the system (Queensland Health, 2013). While conceived of as collaboration, government control is sustained through covert regulation. Tension between different interests is sustained by way, for example, of hospital and community performance reports available to the public.

The professional policy context posed different positions on the concept of collaboration focused on boundary work and professional knowledge, risk and surveillance. Nursing and midwifery policies placed emphasis on scopes of practice, competencies and codes of professional conduct as important indicators of discrete roles and identity. Collaboration is embedded in an unproblematic way within the references to practice, competencies and conduct. Furthermore, a preoccupation was on how an individual profession might prevail over a significant area of healthcare work because of the exclusiveness of the work in the area. Yet the professional policy context simultaneously referred to healthcare consumers as the centre of care. Collaboration was a means to reinforce professional boundaries and ensure professional governance of practice because the concept simultaneously engendered a sense of shared goals, power and knowledge. For example, the term ‘collaborative’ was applied to arrangements between professions to give the appearance of shared goals, power and knowledge. Yet, conditions were being placed upon professional practice to privilege certain professional groups. This conceals how a hierarchy of responsibility and authority in healthcare systems is maintained. Thus the concept of collaboration fulfils many functions in the policy context because it can be invoked to serve disparate interests in different situations. The conceptualisation of collaboration as ambiguous means it is a valuable resource for political and professional interests because it contributes to the veneer of consensus where competing meanings coexist without acknowledgement.

The following section draws together the salient points raised above to focus on the central argument of this thesis. As stated, the argument is that the concept of collaboration serves an important social function in concealing complex power relations within healthcare and associated interests embedded as they are in identity, knowledge and institutions.

9.5 THE SOCIAL FUNCTION OF THE CONCEPT OF COLLABORATION

This research began with an aim to critically explore the meaning of collaboration within the continuum between hospital and community care and to develop a theoretical understanding of the concept. The thesis concludes with the argument that the concept of collaboration serves an important social function in healthcare. The social function of collaboration rests with two salient points; the concealment of complexity and the promulgation of ambiguity. Both points indicate a wider socio-political context for this research because the findings apply across healthcare and raise important questions beyond. The ambiguity surrounding the use of the term collaboration denies the complexity of social relations and becomes a valuable resource to invoke and sustain a status quo that proceeds largely unquestioned. Where it is questioned, the same ambiguity serves to invoke a reality that reproduces desired definitions of a situation through denial of the power relations that exist. Socialisation to ambiguous concepts does not mean that people take them on as their own. Rather, where alternative worlds appear the concepts become realities to be used for specific purposes (Berger & Luckmann, 1966). For example, Berger and Luckmann suggest that to perform certain roles people take on realities deliberately and purposefully and "if this phenomenon becomes widely distributed, the institutional order as a whole begins to take on the character of a network of reciprocal manipulations" (1966, p. 192). Such is the situation around collaboration.

There is a trend in the scholarly, practice and political worlds towards the labelling of all forms of working together as collaboration where any complexities involved are absent (O'Flynn, 2008). The concept is used in healthcare to situate consumers and service users at the centre of interaction and to obscure the political and economic interests that underpin this shift. Ambiguity allows for the term to be used flexibly and without question because it implies something of value without having to justify this in a definitive way. Furthermore, ambiguity renders terms 'useful' since they sustain multiple interpretations that mean different things to different people (McLaughlin, 2004; McLaughlin, Brown, & Young, 2004). Bury and Taylor (2008) have similarly argued that the term partnership functions in altered social relations of healthcare when individual choice is mediated politically within system constraints. As such and in healthcare more broadly, ambiguity opens up opportunities for conceptualising complex situations in ways that reproduce dominant ideologies without the need for justification thereby constructing an ideological frame as the norm.

Health and illness are complex issues that are constructed and reconstructed individually, politically, economically and socially. The redefinition of the medical model on the basis of behavioural, psychological and social aspects of health and disease (Engel, 1977) gave rise to the notion of 'holistic' and individualised healthcare (May, 1995). The assumption is that a more comprehensive care process results in better care. Yet, the holistic approach has extended the boundaries of healthcare and therefore professional control over more and more aspects of peoples' lives as argued through the processes of medicalisation and biomedicalisation (Clarke, et al., 2003). Where healthcare is medicalised through screening and standardised assessment processes, risk and surveillance become the mandate of health professionals. Associated uncertainty over risk preserves the professional position. Here, health professionals, manifest as collaborators and engage in the language of collaboration to legitimate professional control.

Politically and professionally there were situations where responsibility was not justified as shared with consumers; child protection is a moot point here. Situations are rendered more complex because professional systems maintain control over risk and yet are renegotiated to make healthcare appear collaborative and to convey impressions of partnerships and transparency with consumers. This means that responsibility shifts back and forth; ultimately abrogated by default to statutory agencies when shared meanings cannot be reconciled. In a similar way preventive work, reconstructed as risk, is shifted to monitoring in the healthcare relationship. As Morrison (1996) has argued, language such as partnership and collaboration have been imposed upon professional practice to recast relationships and responsibilities between governments, professions and individuals without acknowledgement of inherent tensions.

Thus concepts such as collaboration and partnerships are applied to situations to sustain ambiguity around professional practice. There is a constant tension in any situation where the more powerful seek support for preferred definitions of a situation. This is intensified in professional contexts such as healthcare where workable relations are needed to deal with convergent and divergent perspectives and competing goals. For example, it has been argued that professions compete in different ways to remain relevant to healthcare consumers. Concepts such as collaboration afford the impression of shared goals that belies professional competition. This process does not go unchallenged as other social forces impact legitimacy claims including limits on professional control over life events such as pregnancy, birth and parenting and healthcare consumer choices. The shift from medical dominance to managed consumerism is a further example of how the role of healthcare consumers is appropriated to give the impression of choice, self-management and active engagement in health (Bury & Taylor, 2008).

There is a delicate balance in maintaining significance in the specialised healthcare market. Professions diversify, redefine and extend the boundaries of care as they compete for healthcare market share or move into more specialised areas that carry status and recognition (Biro, 2011; Nancarrow & Borthwick, 2005). An appeal to collaboration facilitates this process as the redefinition of professional work proceeds unchecked. Broad definitions of practice allow health professions to argue such moves without committing to shared ideologies that suggest a consumer focus or partnerships. In other words, because the language of collaboration can be engaged to mean different things in different contexts the concept is professionally useful in the exploitation of evolving healthcare markets.

The concept of collaboration is engaged to conceal how responsibility is negotiated and shared implying that partners may be solely responsible while at other times everyone is responsible in some way. The message is that responsibility always exists on certain terms which may or may not be negotiated. Warde (1994) cautions that this is how freedom to be an individual and to make choices as consumers comes as a double-edged condition because being free from imposed choice also means responsibility is assumed in those choices. This may not fit comfortably with maternity and child health work where individual choice conflicts with what are considered the best interests of women and children. The concept of collaboration, however, justifies monitoring of situations in the interests of a vulnerable child.

In situations where healthcare is individualised, the ambiguous concept of collaboration is also useful. This is because individualised care assumes the focus is primarily on the consumer. For example, one-to-one midwifery, continuity of carer and patient-centred care have been proposed as means whereby women are repositioned with greater individual control over pregnancy, birthing and child care. There are, however, different views on this strategy. One view is that women value a quality of care embodied in respect, consistency and the ability to participate and to take an active role in decision-making (Carolan & Hodnett, 2007). Professionals also gain from continuity because this implies a relationship is formed that elevates the professional role and sustains demand for professional services. For example, carrying 'case loads' of one's own depicts an involved and committed professional (Page, 2003; Stevens & McCourt, 2002). Yet this also functions to maintain surveillance over women because information can be selectively shared where there is the involvement of a limited number of health professionals. Individualisation of healthcare also supports professional practice as dependencies narrow opportunities for shared knowledge and diverts attention from the idea of healthcare consumer as expert. An inherent tension exists whereby the professionalisation of healthcare, through the operation of specialist knowledge, conflicts with positions of mutuality in relationships with patients (Boreham, 2002; May, 1990, 1995).

There is an assumption that healthcare consumers and professionals work together and make joint decisions despite the existence of different goals and meanings. A view on this suggests consensus can be shaped for different purposes when 'collaborative partners' are carefully chosen or information is selectively shared. Collaboration conceals how unequal access to resources around decision-making, limited personal resources for health and unequal power in negotiations limit participation. It also conceals how people are socialised to hierarchies of knowledge and credibility which restricts negotiability or shapes it in particular ways.

Health professionals seek to collaborate through individualisation, for example, being 'out of uniform' and claims on being 'with women' as individualised models of care (Carolan & Hodnett, 2007; Reiger & Lane, 2009; Stevens & McCourt, 2002). Professionals are helpers, carers and partners in the name of collaboration. This implies healthcare relationships are continually open for individual negotiation while this research has indicated there are limits on this. The language of family and woman-centred care places a greater burden on healthcare systems because concepts of individualised care conflict with how finite resources and contemporary complexities such as the casualisation of the nursing and midwifery workforce impact upon what can be negotiated. Further, where individualisation focuses on what makes people unique rather than what is shared this becomes the antithesis of previous assumptions around collaboration. The concept of collaboration mediates the presence of conflicting ideologies and complexities to give the impression of order.

The concept of collaboration also permits care relationships to transform when professional distance becomes necessary such as where healthcare consumers are determined to make decisions that are unsafe. Positioning collaboration between professionals means that situations involving healthcare consumers can be legitimately challenged. Where the focus of collaboration shifts like this, interactions become problematic because a negotiated process, although implied, may not occur. This research has revealed the ways in which numerous issues were deemed non-negotiable and collaboration thereby functioned to serve different interests at strategic times.

Finally the research findings point to potential losses in the collaborative process. This includes loss of professional identity when control over two of the most important resources for professional dominance, knowledge and clients, is shared as the concept of collaboration implies. Defining nursing and midwifery in terms of the client justifies and consolidates powerful positions. Yet where professions are defined in terms of clients alone, there is a risk of becoming irrelevant because clients are positioned as agents and consumers in their own right. The implication is that professional knowledge and authority can be bypassed if desired. The concept of collaboration with healthcare consumers is thus a precarious position. It also represents a potential loss for healthcare consumers when burdened differentially with decisions framed collaboratively or where responsibility shifts back and forth without notice.

The argument presented in this thesis is that the concept of collaboration is drawn into situations to obscure power relations and to deny the complexity of social relations in healthcare. As previously asserted, there is a trend in healthcare toward labelling all forms of working together in terms of collaboration. In so doing, healthcare consumers, professions and governments become ultimately socialised to the concept in a way that allows that which is defined as collaboration to proceed unquestioned. Terms such as collaboration and partnership risk becoming “Humpty Dumpty” terms (Powell & Glendinning, 2002, p. 2) because when something is called collaboration by definition it becomes so. Similar assertions have been made about the diversity of meanings for terms or concepts and how these serve strategic and opportunistic needs. Examples are concepts such as ‘interdisciplinary teamwork’ as explored by Temkin-Greener (1983), ‘community’ and ‘participation’ referred to by Fawcett and Hanlon (2009), ‘patient empowerment’ as serving medical interests (Salmon & Hall, 2003), ‘client collaboration’ to articulate how social workers negotiate shared power in terms of knowledge and decision making (Levin, 2010), ‘patient-centredness’ in cancer care (Salmon, 2010), ‘informed choice’ in midwifery care (Veinot, 2010) and ‘consultation’ in social work practice (McLaughlin, et al., 2004). As this thesis has argued, however, rather than adopting an unquestioning and simplistic attitude to such concepts the very appearance of concepts such as collaboration in practice should assume the presence of particular interests and justify a critical examination of what is occurring. The implications for this research will elaborate this point further.

9.6 IMPLICATIONS OF RESEARCH FINDINGS

9.6.1 The Process of Health Policy

The aim of this research was to uncover what was occurring in the practice setting and to examine professional and government policymaking in relation to practice. The approach has highlighted significant practice/theory disjuncture and suggests that policy-making processes need to be much more closely aligned with the interactional level of healthcare. Policy-making is not necessarily deliberative but is influenced by competing interests and factors other than empirical evidence, such as personal values, beliefs and prejudices, political agendas, the actions of bureaucrats, lobbyists, pressure groups and media as well as simple pragmatism (Howard, 2012). It has also been recognised that policy development ‘on the run’, a feature of government in times of crisis and during electioneering, results in policies that demonstrate partial or inaccurate understanding (Howard, 2012). Australian Public Service reform has argued for a stronger link between policy development and implementation and stronger connections with citizens in service design (Advisory

Group on Reform of Australian Government Adminstration, 2010) to draw on different accounts of what constitutes valid knowledge.

Research such as this, built on a social framework underpinned by social constructionism, recognises that policy-making is informed by contextual knowledge and realities. As Greenhalgh and Russell argue "...policymaking is not about applying objective evidence to solve problems that are 'out there' waiting for solutions" but rather takes into account how problems are constructed through negotiation, deliberation and ongoing change (2009, p. 315). The complexities beneath the veneer of collaboration mean that policy-making needs to be better informed by the knowledge that critical and interpretive approaches bring to research on healthcare. Such knowledge fits more comfortably with policy reforms that seek to engage a wider range of perspectives on healthcare concerns. Furthermore, knowledge and meanings constitute a process and therefore policy-making that assumes the individual and society as coterminous is reflective of social change. This moves policy-making into a space where it is conceived of as an iterative, capacity building process tolerant of uncertainty and complexity and not a linear, systematic and positivistic endeavour. Policy-making has assumed an attitude where empirically generated knowledge subverts experience, local information and citizen engagement or embeds change based on partisan, professional and personal influences (Greenhalgh & Russell, 2009; Howard, 2012; Lewis, 2006). The argument posed is that critical and interpretive perspectives are equally needed to inform the political process.

9.6.2 Nursing, Midwifery and Academic Scholarship

The framework adopted here is not one frequently seen in explorations of concepts such as collaboration. This highlights some points for academia, for the professions of midwifery and nursing and for other healthcare professions. First, nursing and midwifery education needs to more obviously engage in critical reflexive research in order to better understand complexities in healthcare. Second, further research from a theoretical position that perceives the social and individual worlds as one will generate critical evidence that may contribute to policy-making processes and allow for professional perspectives to be more fully informed. Third, understanding policy reform around greater citizen involvement in service design and policy processes (Advisory Group on Reform of Australian Government

Adminstration, 2010, p. v) will enable CHNs and midwives to be prepared for and question situations where contradictions are set up through political and professional processes.

Knowledge of policy is poor at the practice level (Hart & Lockey, 2002). It is recommended, therefore, that nursing and midwifery curricula engage more critically with policy as a tool to understand how political processes around collaboration, for example, shape practice and to consider what may underpin such terms. This begets an understanding of how policy acts to constrain as well as guide practice so that policies exist to serve nursing, not nursing to serve policies (Cheek & Gibson, 1997). The focus of maternity and child health policy across Australian states and territories on prevention and early intervention, continuity of care, collaboration and integrated service is congruent with international research (Schmied, et al., 2011). If the assertion of Schmied and colleagues (2011) is correct that the time is right to consider national approaches to maternal and child health services then it is vital that CHNs and midwives become active in policy processes. The theoretical understandings developed in this thesis have implications for this process in advocating that policy language is examined for latent meanings.

It is hoped that a theoretical understanding of collaboration as posed in this research will engender more critical debate and counter the adoption of uncritical views in healthcare professions generally. This outcome will position CHNs, midwives and others more strategically ‘at the table’ for professional and political consultation and able to reveal obscure assumptions that reproduce certain interests. It should also encourage undergraduate and postgraduate scholars to adopt a more critical position on what constitutes healthcare concerns and to challenge taken for granted assumptions around so-called innovations in healthcare.

Further, the research advocates for the adoption of more flexibility in research methods through the application of the tools of the grounded theory method in ways that harmonise with research frameworks and specific contexts. It is argued that flexible use of such tools is most applicable in critical engagement with situations where questions of what, how and, in particular, *why* situations exist. This is important in exploring socially complex situations and understanding concepts such as collaboration within broader historical and social conditions. The approach advocated is to peel away the descriptive veneer and to look in a more critical way at how concepts serve social and political interests. The development of research methods in this way will further the debate on the ambiguities of grounded theory method in contemporary nursing, midwifery and healthcare scholarship.

9.6.3 Challenging Consumerism: Collaboration and the Partnership Ideal

This research has explored how complex situations can be concealed where concepts such as collaboration and partnerships in practice are represented as co-existing in systems that are dominated by professional and organisational interests. The discourse of consumerism in healthcare and in society in general positions consumers as responsible for their own needs while professional and political systems inhibit the possibility of fulfilling such an objective. Yet a predilection with the consumer society sustains the notion of actors who must compete for health within a market economy that attributes certain value to products such as knowledge and suggests an equal access to resources for all. Hence consumerism gives rise to contradictions which places responsibility on professions to look more critically at situations where the language of collaboration dominates. More debate is needed around the implications for society and professional practice where, for example, confronting social problems such as child protection to consider if professional and consumer views can coexist when consumers are not involved. Indeed, the notion of consumerism sits uncomfortably with both the social determinants of health that place restrictions on vulnerable groups and those members of society such as infants and children who are not represented as collaborators or consumers.

For governments this presents significant challenges in implementing policies that talk at once about choice and responsible regulation and use of the concept of collaboration to conceal differing interests. This gives rise to questions about the level at which governments will accept the financial implications of the empowered and responsible consumer who may well exercise choice for which there are potentially negative consequences. It also raises questions about processes of policy and healthcare reform that deny and conceal contradictions and complexities existing at the practice level.

9.6.4 The Language of Collaboration

This research has concluded that there are various ways that situations and interests in healthcare are represented and misrepresented through the use of the concept of collaboration. Concepts are applied to complex situations without clarity of meaning. While ambiguity functions as a veneer for what may be otherwise occurring it does not go without consequence. A range of assumptions sustain various meanings while other more significant issues are obscured. There are risks associated with the adoption of concepts without looking critically to see the less obvious. Working collaboratively is framed simplistically. For example, the language of working collaboratively in partnership assumes a simplistic co-existence of the concepts that is not borne out in practice. Rather than adopt uncritically the language of collaboration the conceptualisation of human interaction through identity, knowledge, institutions and policy provides a more useful framework from which to assume a critical stance on complex concerns.

9.7 COMMENTS ON THE RESEARCH

The framework adopted for the research acknowledges the contextually situated realities that existed in a specific healthcare situation. Although this may imply that the application of findings is limited it has been argued above that the theoretical outcomes have relevance that extends beyond nursing and midwifery, the specific healthcare context and the healthcare system. This is because the social framework for this research focused on process and gaining a theoretical understanding that went beyond description. The researcher acknowledges that the research process was actively shaped during data collection and analysis. Decisions were made about first, the codes and concepts that were deemed to be significant processes and issues; second, which codes and concepts were followed up in further data collection and theoretical sampling; and third how categories of data and concepts were applied and connected with other concepts (Charmaz, 1990). Furthermore, while the research began with some assumptions about women with complex needs as a basis for women to work together with health professionals, this idea was contested in the research. All situations involving the CHNs, midwives and women were perceived as complex. It was not conceived by the researcher that other conceptual ideas such as partnerships in care would become significant in the development of the theoretical understanding of the concept of collaboration. Thus limitations were also strengths of the approach adopted here because the participants, as much as the researcher, shaped the research situation as it unfolded.

As a CHN and midwife, the researcher worked in the practice area involved in this research. Although a direct line manager to very few of the participants, the researcher was a colleague to various professional participants. The researcher had limited contact in the clinical setting during recruitment and when interviews were conducted. No CHNs or midwives were excluded from the research if they indicated a desire to be involved in the research process. Yet a potential limitation of this situation was that data collected from participants, as work colleagues, may be shaped through such affiliations.

Finally, while it is acknowledged that many healthcare professionals play an important part in the care continuum from maternity to community healthcare settings; midwives, women and CHNs were deemed the prime focus. The view of families and partners of the women were not included, nor those of other healthcare professionals. Other stakeholders, however, did contribute to the conceptualisation and practice of collaboration as recognised by the social view on knowledge and meaning adopted.

9.8 CONCLUSION

The research has generated a theoretical understanding of collaboration as a dynamic, fluid and ambiguous concept. It has been argued that the concept thereby fulfils an important social function in healthcare and beyond. The first point concerns how the language of collaboration conceals much of the complexity that exits in healthcare including how power relations are sustained while the overall impression of shared power and order continues to meet potentially rival individual, professional, organisational and political needs. Rival definitions and divergent interests are concealed in the application of the concept of collaboration so that situations can be handled without the necessity for shared knowledge, values, power, decision-making and goals. Further, the concept of collaboration, by way of ambiguity, conceals how power and authority exist without full acknowledgement of the part the factors play in situations. Ambiguity allows contradictory positions that are inherent in healthcare to coexist sustaining the impression of negotiated social processes. Concepts can take on multiple meanings which allow predominant views about social situations to be reproduced and reconfigured for specific purposes and to proceed largely unquestioned.

In conclusion, this thesis has argued how collaboration has an important social function in healthcare through the concealment of complexity and the promulgation of ambiguity. The conclusion is that healthcare professionals, consumers and political interests must remain alert to what is potentially concealed where the language of collaboration is engaged and to explore more critically what is at hand. The adoption of a critical stance assumes that what is not immediately obvious is very likely significant.

Bibliography

Advisory Group on Reform of Australian Government Adminstration. (2010). *Ahead of the Game: Blueprint for the Reform of Australian Government Administration*. Retrieved from www.ag.gov.au/cca.

Alaszewski, A., & Brown, P. (2012). *Making Health Policy: A Critical Introduction*. Cambridge: Polity Press.

Alford, R. R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: The University of Chicago Press.

Allen, R. I., & Petr, C. G. (1998). Rethinking family-centered practice. *American Journal of Orthopsychiatry, 68*(1), 4-15.

Alvesson, M. (2011). *Interpreting Interviews*. London: SAGE Publications Limited.

Alvesson, M., & Karreman, D. (2011). *Qualitative Research and Theory Development: Mystery as Method*. London: SAGE Publications Limited.

Alvesson, M., & Sandberg, J. (2011). Generating research questions through problematization. *Academy of Management Review, 36*(2), 247-271.

Alvesson, M., & Sandberg, J. (2013). *Constructing Research Questions: Doing Interesting Research*. London: SAGE Publications Limited.

Alvesson, M., & Skoldberg, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research* (2nd ed.). London: SAGE Publications Limited.

American Academy of Pediatrics. (2008). Hospital discharge of the high-risk neonate. *Pediatrics, 122*(5), 119-1126.

Anderson, H. (1990). Then and now: a journey from "knowing" to "not knowing". *Contemporary Family Therapy, 12*(3), 193-197.

Appleton, J. V., & Cowley, S. (2004). The guideline contradiction: health visitors' use of formal guidelines for identifying and assessing families in need. *International Journal of Nursing Studies, 41*(7), 785-797.

Appleton, J. V., & Cowley, S. (2008). Health visiting assessment processes under scrutiny: a case study of knowledge use during family health needs assessments. *International Journal of Nursing Studies, 45*(5), 682-696.

Armitage, S., & Kavanagh, K. (1996). The discharge liaison nurse at the interface of hospital and community nursing services. *International Journal of Nursing Practice, 2*(4), 215-221.

Armstrong, D. (1983). The fabrication of nurse-patient relationships. *Social Science and Medicine, 17*(8), 457-460.

Armstrong, D. (1987). Theoretical tensions in biopsychosocial medicine. *Social Science and Medicine, 25*(11), 1213-1218.

Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health and Illness, 17*(3), 393-404.

Atwal, A. (2002). Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Journal of Advanced Nursing, 39*(5), 450-458.

Australian College of Children and Young People's Nurses. (2009). *Position Statement: Minimum Standard for Nurses Caring for Children and Young People*. Retrieved from www.accypn.org.au/wp-content/uploads/091016-POSITION-STATEMENT-Minimum-Standards.pdf.

Australian College of Midwives. (2013). *National Midwifery Guidelines for Consultation and Referral* (3rd ed.). Canberra: Australian College of Midwives.

Australian Health Ministers' Advisory Council. (2010). *National Maternity Services Capability Framework*. Retrieved from www.qcmb.org.au/policy.

Australian Health Ministers' Advisory Council. (2011). *National Framework for Universal Child and Family Health Services*.

Australian Health Ministers' Conference. (2009). *The Australian National Breastfeeding Strategy 2010-2015*. Canberra: Australian Government Department of Health and Ageing.

Australian Health Ministers' Conference. (2011). *National Maternity Services Plan*. Retrieved from www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesplan.

Australian Institute of Health and Welfare. (2012). *Australia's Health 2012*. Canberra: Australian Institute of Health and Welfare.

Australian Medical Association. (2010). Collaborative Arrangements: What You Need to Know. Retrieved from www.ama.com.au/collaborative-arrangements-what-you-need-know

Australian Research Alliance for Children and Youth. (2010). *Working Together to Prevent Child Abuse and Neglect - A Common Approach for Identifying and Responding Early to Indicators of Need*. Canberra.

Baggs, J. G., & Schmitt, M. H. (1988). Collaboration between nurses and physicians. *IMAGE: Journal of Nursing Scholarship, 20*(3), 145-149.

Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: stories of collaboration. *Journal of Advanced Nursing, 53*(4), 381-391.

Bajaj, M., Mease, R. G., Allen, K., & Dryburgh, E. H. (2006). Safeguarding children - is there a role for a coordinator. *Child Abuse Review, 15*, 127-137.

Barimani, M., & Hylander, I. (2008). Linkage in the chain of care: a grounded theory of professional cooperation between antenatal care, postpartum care and child health care. *International Journal of Integrated Care, 8*, 1-13.

Becker, H. S. (1967). Whose side are we on? *Social Problems, 14*(3), 239-247.

Beckman, K., Sakulkoo, S., Hofart, N., & Cobb, A. K. (2002). Barriers to successful implementation of a clinical pathway for CHF. *Journal for Healthcare Quality, 24*(5), 32-38.

Bell, K., Kinder, T., & Huby, G. (2008). What goes around goes around: on the language and practice of 'integration' in health and social care in Scotland. *Journal of Integrated Care, 16*(4), 40-48.

Bella, L. (2010). In Sickness and in Health: Public and Private Responsibility for Health Care from Bismarck to Obama. In R. Harris, N. Wathen & S. Wyatt (Eds.), *Configuring Health Consumers: Health Work and the Imperative of Personal Responsibility*. London: Palgrave Macmillan.

Bellamy, A., Fiddian, M., & Nixon, J. (2006). Case reviews: promoting shared learning and collaborative practice. *International Journal of Palliative Nursing, 12*(4), 158-162.

Berger, P. (1966). Identity as a problem in the sociology of knowledge. *European Journal of Sociology, 7*(1), 105-115.

Berger, P. L., & Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York: Anchor Press.

Bernard, H. R., & Ryan, G. W. (2010). *Analyzing Qualitative Data: Systematic Approaches*. London: SAGE Publications Limited.

Biro, M. A. (2011). What has public health got to do with midwifery? Midwives' role in securing better heatlh outcomes for mothers and babies. *Women and Birth, 24*(1), 17-23.

Blower, K., & Morgan, E. (2000). Great expectations? Parental participation in care. *Journal of Child Health Care, 4*(2), 60-65.

Blumer, H. (1966). Sociological implications of the thought of George Herbert Mead. *American Journal of Sociology, 71*(5), 535-544.

Blumer, H. (1969). *Symbolic Interactionism: Perspective and Method*. Berkeley: University of California Press.

Bolam, B., Gleeson, K., & Murphy, S. (2003). "Lay Person" or "Health Expert"? Exploring Theoretical and Practical Aspects of Reflexivity in Qualitative Health Research. *Forum: Qualitative Social Research, 4*(2), 34 paragraphs. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/699/1515

Boon, H., Verhoef, M., O'Hara, D., & Findlay, B. (2004). From parallel practice to integrative health care: a conceptual framework. *BMC Health Services Research, 4*(15), 1-5.

Boreham, N. (2002). Professionalization and Work Process Knowledge in the UK's National Health Service. In N. Boreham, R. Samurcay & M. Fischer (Eds.), *Work Process Knowledge* (pp. 171-182). New York: Taylor and Francis Group.

Boreham, N. (2004). A theory of collective competence: challenging the neo-liberal individualisation of preformance at work. *British Journal of Educational Studies, 52*(1), 5-17.

Brodie, P. M. (2002). Addressing the barriers to midwifery - Australian midwives speaking out. *Australian College of Midwives Inc, 15*(3), 5-14.

Bryant, A., & Charmaz, K. (2007). Introduction: Grounded Theory Research: Methods and Practices. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 1-28). London: SAGE Publications Limited.

Burke, P. J. (2004). Identities and social structure: the 2003 Cooley-Mead Award address. *Social Psychology Quarterly, 67*(1), 5-15.

Burke, P. J., & Stets, J. E. (2009). *Identity Theory*. New York: Oxford University Press Inc.

Burns, E., Schmied, V., Fenwick, J., & Sheehan, A. (2012). Liquid gold from the milk bar: constructions of breastmilk and breastfeeding women in the language and practices of midwives. *Social Science and Medicine, 75*(10), 1737-1745.

Burr, V. (2003). *Social Constructionism* (2nd ed.). London: Routledge.

Bury, M., & Taylor, D. (2008). Towards a theory of care transition: from medical dominance to managed consumerism. *Social Theory and Health 6*(3), 201-219.

Calnan, M., & Gabe, J. (2001). From consumerism to partnership? Britain's national health service at the turn of the century. *International Journal of Health Services, 31*(1), 119-131.

Canadian Interprofessional Health Collaborative. (2010). *A National Interprofessional Competency Framework*. Vancouver: University of British Colombia.

Carnwell, R., & Carson, A. (2005). Understanding Partnerships and Collaboration. In R. Carnwell & J. Buchanan (Eds.), *Effective Practice in Health and Social Care: A Partnership Approach*. Maidenhead: Open University Press.

Carolan, M. (2007). Health literacy and the information needs and dilemmas of first-time mothers over 35 years. *Journal of Clinical Nursing, 16*(6), 1162-1172.

Carolan, M., & Hodnett, E. (2007). 'With woman' philosophy: examining the evidence, answering the questions. *Nursing Inquiry, 14*(2), 140-152.

Cast, A. D. (2003). Power and the ability to define the situation. *Social Psychology Quarterly, 66*(3), 185-201.

Chalmers, K. I. (1992). Giving and receiving: an empirically derived theory on health visiting practice. *Journal of Advanced Nursing, 17*(11), 1317-1325.

Chamberlain, K. (1999). Using Grounded Theory in Health Psychology: Practices, Premises and Potential. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 183-202). London: SAGE Publications Limited.

Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of Health Psychology, 5*(3), 285-296.

Charmaz, K. (1990). 'Discovering' chronic illness: using grounded theory. *Social Science and Medicine, 30*(11), 1161-1172.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: SAGE Publications Limited.

Charmaz, K. (2008). Constructionism and the Grounded Theory Method. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research*. New York: Guilford Press.

Charmaz, K. (2011). Grounded Theory Methods in Social Justice Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4th ed.). London: SAGE Publications Limited.

Cheek, J., & Gibson, T. (1997). Policy *matters*: critical policy analysis and nursing. *Journal of Advanced Nursing, 25*(4), 668-672.

Cheong, L. H., Armour, C. L., & Bosnic-Anticevich, S. Z. (2013). Multidisciplinary collaboration in primary care: through the eyes of patients. *Australian Journal of Primary Health, 19*(3), 109-197.

Cheung, K. K., Mirzaei, M., & Leeder, S. (2010). Health policy analysis: a tool to evaluate in policy documents the alignment between policy statements and intended outcomes. *Australian Health Review, 34*(4), 405-413.

Chiarella, M., & McInnes, E. (2010). Who to turn to? 'knowing the ropes' in an underbounded health care system. *Contemporary Nurse, 36*(1-2), 10-20.

Children's Health Queensland Hospital and Health Service. (2013). *Children's Health Queensland Strategic Plan: 2013-2017*.

Ciliska, D., Mitchell, A., Baumann, A., Sheppard, K., Van Berkel, C., Adam, V., et al. (1996). Changing nursing practice - trisectoral collaboration in decision making. *Canadian Journal of Nursing Administration, 9*(2), 60-73.

Clark, A. E. (2003). Situational analyses: grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*(2), 161-172.

Colebatch, H. K. (2005). Policy analysis, policy practice and political science. *Australian Journal of Public Administration, 64*(3), 14-23.

Commonwealth of Australia. (2010). National Health (Collaborative Arrangements for Midwives) Determination 2010. Retrieved 25th January, 2014, from www.comlaw.gov.au/Details/F2010L02105

Conklin, J. (2005). Wicked Problems and Social Complexity. Retrieved from http://cognexus.org/wpf/wickedproblems.pdf

Connor, H. (1999). Collaboration or chaos: a consumer perspective. *Australian and New Zealand Journal of Mental Health Nursing, 8*(3), 79-85.

Conrad, P. (1992). Medicalisation and social control. *Annual Review of Sociology, 18*, 209-232.

Contandrioloulos, A.-P., Denis, J.-L., Touati, N., & Rodriguez, C. (2003). The Integration of Health Care: Dimensions and Implementation. University of Monteal.

Cooley, C. H. (1983). Human Nature and the Social Order. London: Transaction Books.

Corlett, J., & Twycross, A. (2006). Negotiation of parental roles within family-centred care: a review of the research. *Journal of Clinical Nursing, 15*(10), 1308-1316.

Council of Australian Governments. (2009a). *Investing in the Early Years - A National Early Childhood Development Strategy*.

Council of Australian Governments. (2009b). *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2012, Implementing the First Three-year Action Plan, 2009-2012*. Canberra: Commonwealth of Australia.

Council of Australian Governments. (2011). *National Health Reform Agreement*. Retrieved from www.coag.gov.au/node/96.

Cowley, S., Mitcheson, J., & Houston, A. M. (2004). Structuring health needs assessments: the medicalisation of health visiting. *Sociology of Health and Illness, 26*(5), 503-526.

Coyne, I., & Cowley, S. (2007). Challenging the philosophy of partnership with parents: a grounded theory study. *International Journal of Nursing Studies, 44*(6), 893-904.

Coyne, I., O'Neill, C., Murphy, M., Costello, T., & O'Shea, R. (2011). What does family-centred care mean to nurses and how do they think it could be enhanced in practice. *Journal of Advanced Nursing, 67*(12), 2561-2573.

Craig, H. J., & Dietsch, E. (2010). 'Too scary to think about': first time mothers' perceptions of the usefulness of antenatal breastfeeding education. *Women and Birth, 23*(4), 160-165.

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Crows Nest: Allen & Unwin.

DÁmour, D., Ferrada-Videla, M., Martin-Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, May*(Supplement 1), 116-131.

DÁmour, D., Goulet, L., Labadie, J., Bernier, L., & Pineault, R. (2003). Accessibility, continuity and appropriateness: key elements in assessing integration of perinatal services. *Health and Social Care in the Community, 11*(5), 397-404.

DÁmour, D., Goulet, L., Ladabie, J.-L., San Martin-Rodriguez, L., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BioMed Central Health Services Research, 8:188.*

Dane, A. C., Thompson, R., & Miller, Y. D. (2011). *A Call for Better Care? Evaluation of the Effectiveness of the Universal Postnatal Contact Services in Improving Women's Satisfaction with Care and Confidence*. Brisbane: Queensland Centre for Mothers and Babies.

Darlington, Y., Feeney, J., & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse and Neglect, 29*(10), 1085-1098.

Davies, B., & Harre, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour, 20*(1), 43-63.

Davis, H., Day, C., & Bidmead, C. (2002). *Working in Partnership with Parents: The Parent Advisor Model*. London: Harcourt Assessment.

Day, M. R., McCarthy, G., & Coffey, A. (2009). Discharge planning: the role of the discharge co-ordinator. *Nursing Older People, 21*(1), 26-32.

de la Cuesta, C. (1994). Marketing: a process in health visiting. *Journal of Advanced Nursing, 19*(4), 347-3553.

Denscombe, M. (2007). *The Good Research Guide: For Small-scale Social Research Projects* (3rd ed.). Berkshire: Open University Press.

Department of Health and Ageing. (2009). *Improving Maternity Services in Australia: The Report of the Maternity Service Review*. Canberra: Commonwealth of Australia.

Department of Health and Ageing. (2010). *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy*. Canberra: Commonwealth of Australia.

Department of Health and Ageing. (2011). *National Health Reform: Progress and Delivery* Retrieved from www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhr-progress-delivery.

Devaney, J. (2008). Inter-professional working in child protection with families with long-term and complex needs. *Child Abuse Review, 17*(4), 242-261.

Devereux, P. M. (1981). Nurse/physician collaboration: nursing practice considerations. *The Journal of Nursing Administration, 11*(9), 37-39.

Dewey, J., & Bentley, A. F. (1949). *Knowing and the Known*. Connecticut: Greenwood Press.

Dey, I. (1999). *Grounding Grounded Theory: Guidelines for Qualitative Inquiry*. California: Academic Press.

Easthope, G. (2004). Complementary Medicine and Orthodox Medicine. In C. Grbich (Ed.), *Health in Australia: Sociological Concepts and Issues* (3rd ed.). Frenchs Forest: Pearson Longman.

Ebert, L., Bellchambers, H., Ferguson, A., & Browne, J. (2013). Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care. *Women and Birth, in press*, 1-6.

Elejabarrieta, F. (1994). Social positioning: a way to link social identity and social representations. *Social Science Information, 33*(2), 241-253.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *American Association for the Advancement of Science, 196*(4286), 129-136.

Etherington, K. (2004). *Becoming a Reflexive Researcher: Using Ourselves in Research*. London: Jessica Kingsley Publishers.

Fawcett, B., & Hanlon, M. (2009). The 'return to community': challenges to human service professionals. *Journal of Sociology, 45*(4), 433-444.

Fenwick, J., Barclay, L., & Schmied, V. (2008). Craving closeness: a grounded theory analysis of women's experiences of mothering in the Special Care Nursery. *Women and Birth, 21*(2), 71-85.

Fenwick, J., Butt, J., Dhaliwal, S., Hauck, Y., & Schmied, V. (2010). Western Australian women's perceptions of the style and quality of midwifery postnatal care in hospital and at home. *Women and Birth, 23*(1), 10-21.

Fewster-Thuente, L., & Velsor-Friedrich, B. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly, 32*(1), 40-48.

Foster-Fishman, P. G., Nowell, B., & Huilan, Y. (2007). Putting the system back into systems change: a framework for understanding and changing organizational and community systems. *American Journal of Community Psychology, 39*(3-4), 197-215.

Fournier, V. (2000). Boundary work and the (un)making of the professions. In N. Malin (Ed.), *Professionalism, Boundaries and the Workplace* (pp. 67-86). London: Routledge.

Fowler, C., Rossiter, C., Bigsby, M., Hopwood, N., Lee, A., & Dunston, R. (2012). Working in partnership with parents: the experience and challenge of practice innovation in child and family health nursing. *Journal of Clinical Nursing, 21*(21-22), 3306-3314.

Freeman, L. (2006). Continuity of carer and partnership: a review of the literature. *Women and Birth, 19*(2), 39-44.

Freese, L., & Burke, P. J. (1994). Persons, identities, and social interaction. *Advances in Group Processes, 11*, 1-24.

Freshwater, D., & Avis, M. (2004). Analysing interpretation and reinterpreting analysis: exploring the logic of critical reflection. *Nursing Philosophy, 5*(1), 4-11.

Freshwater, D., Cahill, J., & Essen, C. (2013). Discourses of collaborative failure: identity, role and discourse in an interdisciplinary world. *Nursing Inquiry, Early view*.

Fridgant, Y., Davies, G. P. P., O'Toole, B. I., Betbeder-Matibet, L., & Harris, M. F. (1998). Integration of General Practitioners with hospitals and community health services: a qualitative examination. *Australian Journal of Primary Health Interchange, 4*(4), 68-78.

Frost, N. (2005). *Professionalism, Partnership and Joined-up Thinking: A Research Review of Front-Line Working with Children and Families*: Devon.

Frost, N., & Robinson, M. (2007). Joining up children's services: Safeguarding children in multi-disciplinary teams. *Child Abuse Review, 16*(3), 184-199.

Furedi, F. (2006). *Culture of Fear Revisited: Risk-taking and the Morality of Low Expectation* (4th ed.). London: Continuum.

Gachoud, D., Albert, M., Kuper, A., Stroud, L., & Reeves, S. (2012). Meanings and perceptions of patient-centredness in social work, nursing and medicine: a comparative study. *Journal of Interprofessional Care, 26*(6), 484-490.

Gallagher, F., & Jasper, M. (2003). Health visitors' experiences of Family Group Conferences in relation to child protection planning: a phenomenological study. *Journal of Nursing Management, 11*(6), 377-386.

Gergen, K. J. (1998). Constructionism and Realism: How Are We to Go On? In I. Parker (Ed.), *Social Constructionism, Discourse and Realism*. London: SAGE Publications Limited.

Gergen, K. J. (2009). *An Invitation to Social Construction* (2nd ed.). London: SAGE Publications Limited.

Gergen, K. J., Lightfoot, C., & Sydow, L. (2004). Social Construction: Vistas in Clinical Child and Adolescent Psychology. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 389-399.

Gergen, M. G., & Gergen, K. J. (2003). *Social Construction: A Reader*. London: SAGE Publications Limited.

Gildea, A., Sloan, S., & Stewart, M. (2009). Sources of feeding advice in the first year of life: who do parents value? *Community Practitioner, 82*(3), 27-31.

Giles, T., King, L., & de Lacey, S. (2013). The timing of the literature review in grounded theory research: an open mind versus an empty head. *Advances in Nursing Science, 36*(2), E29-E40.

Gittell, J. H., Godfrey, M., & Thistlethwaite, J. (2013). Interprofessional collaborative practice and relational coordination: improving healthcare through relationships. *Journal of Interprofessional Care, 27*(3), 210-213.

Given, B., & Simmons, S. (1977). The interdisciplinary health-care team: fact or fiction? *Nursing Forum, 16*(2), 165-184.

Glaser, B. G. (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley: The Sociology Press.

Glaser, B. G. (1998). *Doing Grounded Theory: Issues and Discussions*. Mill Valley: Sociology Press.

Glaser, B. G. (1999). The Future of Grounded Theory: Keynote Address from the Fourth Annual Qualitative Health Research Conference. *Qualitative Health Research, 9*(6), 836-845.

Glaser, B. G. (2007). All is data. *The Grounded Theory Review, 6*(2), 1-22.

Glaser, B. G., & Strauss, A. L. (1964). Awareness contexts and social interaction. *American Sociological Review, 29*(5), 669-679.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401-421.

Goffman, E. (1967). Presentation of Self to Others. In D. Mann & B. N. Meltzer (Eds.), *Symbolic Interaction: A Reader in Social Psychology*. Boston: Allyn & Bacon.

Goffman, E. (1973). *The Presentation of Self in Everyday Life*. New York: The Overlook Press.

Goffman, E. (1974). *Frame Analysis: An Essay on the Organization of Experience*. Middlesex: Penguin Books Limited.

Goffman, E. (1983). The interaction order: American Sociological Association,1982 presidential address. *American Sociological Review, 48*(1), 1-17.

Gould, N., & Gould, E. (2001). Health as a consumption object: research notes and preliminary investigation. *International Journal of Consumer Studies, 25*(2), 90-101.

Grealish, L. (2012). How competency standards became the preferred national technology for classifying nursing performance in Australia. *Australian Journal of Advanced Nursing, 30*(2), 20-31.

Greenhalgh, T., & Russell, J. (2009). Evidence-based policymaking: a critique. *Perspectives in Biology and Medicine, 52*(2), 304-318.

Gubrium, J. F., & Holstein, J. A. (2008). The Constructionist Mosaic. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research*. New York: The Guilford Press.

Hacking, I. (1999). *The Social Construction of What*. Cambridge: Harvard University Press.

Hall, J. L., & van Teijlingen, E. R. (2006). A qualitative study of an integrated maternity, drugs and social care service for drug-using women. *BioMed Central Pregnancy and Childbirth, 6*, 19.

Hallett, T., & Ventresca, M. J. (2006). Inhabited institutions: social interactions and organizational forms in Gouldner's *Patterns of Industrial Bureaucrary. Theory and Society, 35*(2), 213-236.

Halpern, S. A. (1990). Medicalization as professional process: postwar trends in pediatrics. *Journal of Health and Social Behavior, 31*(1), 28-42.

Harris, M. F., Chan, B. C., Daniel, C., Wan, Q., Zwar, N., & Davies, G. P. (2010). Development and early experience from an intervention to facilitate teamwork between general practices and allied health providers: the Team-link study. *BioMed Central Health Services Research, 10:104*.

Hart, A., & Lockey, R. (2002). Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England. *Journal of Advanced Nursing, 37*(5), 485-493.

Health Professions Networks Nursing and Midwifery Office. (2010). *Nursing and Midwifery Services: Strategic Directions 2011-2015*. Retrieved from www.who.int/hrh/nursing_midwifery/en/.

Heatley, M., & Kruske, S. (2011). Defining collaboration in Australian Maternity Care. *Women and Birth, 24*(2), 53-57.

Heidegger, M. (1953/1996). *Being and Time: A Translation of Sein und Zeit* (J. Stambaugh, Trans. 1996, 7th ed.). New York: State University of New York Press.

Heinig, M. J., Ishii, K. D., Banuelos, J. L., Campbell, E., O'Loughlin, C., & Becerra, L. E. V. (2009). Sources and acceptance of infant-feeding advice among low-income women. *Journal of Human Lactation, 25*(2), 163-172.

Henneman, E. A., Lee, J. L., & Cohen, J. I. (1995). Collaboration: a concept analysis. *Journal of Advanced Nursing, 21*(1), 73-82.

Herbert, C., Bainbridge, L., Bickford, J., Baptiste, S., Brajtman, S., Dryden, T., et al. (2007). Factors that influence engagement in collaborative practice: How 8 health professionals became advocates. *Canadian Family Physician, 53*(8), 1318-1325.

Hesse, M., Vanderplasschen, W., Rapp, R., Broekaert, E., & Fridell, M. (2007). Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*(4).

Hibberd, P. A. (1998). The primary/secondary interface. Cross boundary teamwork - missing link for seamless care? *Journal of Clinical Nursing, 7*, 274-282.

Hirst, C. (2005). *Re-Birthing: Report of the Review of Maternity Services in Queensland*. Brisbane.

Hofmeyer, A., & Clare, J. (1999). The role of the hospital liaison nurse in effective discharge planning for older people: perspectives of discharge planners. *Contemporary Nurse, 8*(3), 99-106.

Hogg, M. A. (2005). Uncertainty, social identity, and ideology. *Advances in Group Processes: Social Identification in Groups, 22*, 203-229.

Hogg, M. A., Terry, D. J., & White, K. M. (1995). A tale of two theories: a critical comparison of identity theory with social identity theory. *Social Psychology Quarterly, 58*(4), 255-269.

Holland, D. E., & Harris, M. R. (2007). Discharge planning, transitional care, coordination of care, and continuity of care: Clarifying concepts and terms from the hospital perspective. *Home Health Care Services Quarterly, 26*(4), 3-19.

Homer, C. S. E., Davis, G. K., Cooke, M., & Barclay, L. M. (2002). Women's experiences of continuity of midwifery care in a randomised controlled trial in Australia. *Midwifery, 18*(2).

Homer, C. S. E., Henry, K., Schmied, V., Kemp, L., Leap, N., & Briggs, C. (2009). 'It looks good on paper' Transitions of care between midwives and child and family health nurses in New South Wales. *Women and Birth, 22*(2), 64-72.

Homer, C. S. E., Passant, L., Brodie, P. M., Kildea, S., Leap, N., Pincombe, J., et al. (2009). The role of the midwife in Australia: views of women and midwives. *Midwifery, 25*(6), 673-681.

Hopwood, N., Flowler, C., Lee, A., Rossiter, C., & Bigsby, M. (2013). Understanding partnership practice in child and family nursing through the concept of practice architectures. *Nursing Inquiry, 20*(3), 199-210.

Hoskins, M. (2011). Not-knowing or knowing naught: revisiting the concept of collaboration and expertise in child and youth care practice. *Child and Youth Services, 32*(2), 124-134.

Houghton, A., Bowling, A., Clarke, K. D., Hopkins, A. P., & Jones, I. (1996). Does a dedicated discharge coordinator improve the quality of hospital discharge? *Quality and Safety in Health Care, 5*(2), 89-96.

Howard, J. H. (2012). *Public Policy Drift: Why Governments Must Replace 'Policy on the Run' and 'Policy by Fiat' with a 'Business Case' Approach to Regain Public Confidence*. Retrieved from www.partnershipforum.dpc.wa.gov.au/pages/search.aspx?k=public%20policy%20drift.

Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery, 22*(4), 308-322.

Hunter, J. D., & Ainlay, S. C. (1986). Introduction. In J. D. Hunter & S. C. Ainlay (Eds.), *Making Sense of Modern Times*. London: Routledge and Kegan Paul.

Jack, S. M., DiCenso, A., & Lohfeld, L. (2005). A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing, 49*(2), 182-190.

Jackson, A. Y., & Mazzei, L. A. (2013). Plugging one text into another: thinking with theory in qualitative research. *Qualitative Inquiry, 19*(4), 261-271.

James, W. (1890). *The Principles of Psychology* (Vol. 1). New York: Henry Holt and Company.

Jenkinson, B., Young, K., & Kruske, S. (2013). Maternity services and the discharge process: a review of practice in Queensland. *Women and Birth, in press*, 1-7.

Johnson, L. J., Zorn, D., Kai Yung Tam, B., Lamontagne, M., & Johnson, S. A. (2003). Stakeholders' views of factors that impact successful interagency collaboration. *Exceptional Children, 69*(2), 195-209.

Jones, S. R., Torres, V., & Arminio, J. (2006). *Negotiating the Complexities of Qualitative Research in Higher Education*. New York: Routledge, Taylor and Francis Group.

Jordan, R. G., & Murphy, P. A. (2009). Risk assessment and risk distortion: finding the balance. *Journal of Midwifery and Women's Health, 54*(3), 191-200.

Katz, B. (2012). New focus on family-centered maternity care. *International Journal of Childbirth Education, 27*(3), 99-102.

Katz, L., Ceballos, S. G., Scott, K., & Wurum, G. (2007). The critical role of a pediatric nurse practitioner in an early intervention program for children with prenatal drug exposure. *Journal for Specialists in Pediatric Nursing, 12*(2), 123-127.

Keast, R., & Mandell, M. P. (2011a). Collaborative Competencies/Capabilities. *Australian Research Alliance for Children and Youth, Fact Sheet 14*, 1-3.

Keast, R., & Mandell, M. P. (2011b). Power and Collaboration. *Australian Research Alliance for Children and Youth, Fact Sheet 13*, 1-3.

Keat, R., Whiteley, N., & Abercrombie, N. (1994). Introduction. In R. Keat, N. Whiteley & N. Abercrombie (Eds.), *The Authority of the Consumer*. London: Routledge.

Keatinge, D., Fowler, C., & Briggs, C. (2007-08). Evaluating the Family Partnership Model (FPM) program and implementation in practice in New South Wales, Australia,. *Australian Journal of Advanced Nursing, 25*(2), 28-35.

Kelle, U. (2005). "Emergence" vs. "Forcing" of empirical data? A Crucial problem of "grounded theory" reconsidered. *Forum: Qualitative Social Research, 6*(2).

Knaak, S. J. (2010). Contextualising risk, constructing choice: breastfeeding and good mothering in risk society. *Health, Risk and Society, 12*(4), 345-355.

Koerner, B. L., Cohen, J. R., & Armstrong, D. M. (1985). Collaborative practice and patient satisfaction: impact and selected outcomes. *Evaluation and the Health Professions, 8*(3), 299-321.

Kraus, W. A. (1984). *Collaboration in Organizations: Alternatives to Hierarchy*. New York: Human Sciences Press.

Kruske, S., Barclay, L., & Schmied, V. (2006). Primary health care, partnership and polemic: child and family health nursing support in early parenting. *Australian Journal of Primary Health, 12*(2), 57-65.

Kruske, S., & Heatley, M. (2010). *Results of the Survey on Collaboration in Queensland Maternity Care*. Brisbane: Queensland Centre for Mothers and Babies.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the Craft of Qualitative Research Interviewing* (2nd ed.). London: SAGE Publications Limited.

Laming, L. (2003). The Victoria Climbe Inquiry. Retrieved 12th June, 2009, from www.victoria-climbe-inquiry.org.uk

Lane, K. (2006). The plasticity of professional boundaries: A case study of collaborative care in maternity services. *Health Sociology Review, 15*(4), 341-352.

Lane, K. (2012a). Dreaming the impossible dream: ordering risks in Australian maternity care policies. *Health Sociology Review, 21*(1), 23-35.

Lane, K. (2012b). When is collaboration not collaboration? When it's militarized. *Women and Birth, 25*(1), 29-38.

Larson, M. S. (1977). *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.

Larsson, M., Aldegarmann, U., & Aarts, C. (2009). Professional role and identity in a changing society: three paradoxes in Swedish midwives' experiences *Midwifery, 25*(4), 373-381.

Lee, P. (2007). What does partnership in care mean for children's nurses? *Journal of Clinical Nursing, 16*(3), 518-526.

Levin, L. (2010). Towards a revised definition of client collaboration: the knowledge-power-politics triad. *Journal of Social Work Practice, 26*(2), 181-195.

Lewis, J. M. (2006). Being around and knowing the players: networks of influence in health policy. *Social Science and Medicine, 62*(9), 2125-2136.

Lillibridge, J., Axford, R., & Rowley, G. (2000). The contribution of nurses' perceptions and actions in defining scope and stabilising professional boundaries of nursing practice. *Collegian, 7*(4), 35-39.

Lishman, J. (1983). *Collaboration and Conflict: Working with Others* (Vol. 7). Aberdeen: Department of Social Work.

Long, J. C., Cunningham, F. C., & Braithwaite, J. (2013). Bridges, brokers and boundary spanners in collaborative networks: a systematic review. *BioMed Central Health Services Research, 13*(158), 1-13.

Lothian, J. A. (2012). Risk, safety, and choice in childbirth. *The Journal of Perinatal Education, 21*(1), 45-47.

Ludlow, V., Newhook, L. A., Newhook, J. T., Bonia, K., Goodridge, J. M., & Twells, L. (2012). How formula feeding mothers balance risks and define themselves as 'good mothers'. *Health, Risk and Society, 14*(3), 291-306.

Lupton, D., & Fenwick, J. (2001). 'They've forgotten that I'm the mum' : constructing and practising motherhood in special care nurseries. *Social Science and Medicine, 53*(8), 1011-1021.

Lusk, J. M., & Fater, K. (2013). A concept analysis of patient-centred care. *Nursing Forum, 48*(2), 89-98.

Maher, J. H., Hughes, R., Anderson, C., & Lowe, J. B. (2013). An exploratory investigation amongst Australian mothers regarding pharmacies and opportunities for nutrition promotion. *Health Education Research 28*(6), 1040-1050.

Mailick, M. D., & Jordan, P. (1977). A multimodel approach to collaborative practice in health settings. *Social Work in Health Care, 2*(4), 445-454.

Malone, M. F. (1964). The dilemma of a professional in a bureaucracy. *Nursing Forum, 3*(4), 36-60.

Manning, P. K. (1977). Rules in Organizational Context: Narcotics Law Enforcement in Two Settings. *The Sociological Quarterly, 18*, 44-61.

May, C. (1990). Research on nurse-patient relationships: problems of theory, problems of practice. *Journal of Advanced Nursing, 15*(3), 307-315.

May, C. (1995). Patient autonomy and the politics of professional relationships. *Journal of Advanced Nursing, 21*(1), 83-87.

McBryde-Foster, M., & Allen, T. (2005). The continuum of care: a concept development study. *Journal of Advanced Nursing, 50*(6), 624-632.

McCallin, A. (2003). Grappling with the literature in a grounded theory study. *Contemporary Nurse, 15*(1-2), 61-69.

McIntyre, M., Francis, K., & Chapman, Y. (2012). The struggle for contested boundaries in the move to collaborative care teams in Australian maternity care. *Midwifery, 28*(3), 298-305.

McKenna, H., Kenney, S., Glenn, A., & Gordon, P. (2000). Dischage planning: an exploratory study. *Journal of Clinical Nursing, 9*(4), 594-601.

McLaughlin, H. (2004). Partnerships: panacea or pretence? *Journal of Interprofessional Care, 18*(2), 103-113.

McLaughlin, H., Brown, D., & Young, A. M. (2004). Consultation, community and empowerment. *Journal of Social Work, 4*(153), 153-165.

Mead, G. H. (1934). Mind, Self and Society: From the Standpoint of a Social Behaviorist. In C.W.Morris (Ed.). Chicago: University of Chicago Press.

Meads, M., Ashcroft, J., Barr, H., Scott, R., & Wild, A. (2005). *The Case for Interprofessional Collaboration: In Health and Social Care*. Oxford: Blackwell Publishing Ltd.

Menzies, I. E. P. (1960). A case study in the functioning of social systems as a defense against anxiety. *Human Relations, 13*(2).

Metro North Hospital and Health Service. (2013). *Strategic Plan 2013-17*

Michailakis, D., & Schirmer, W. (2010). Agents of their health? How the Swedish welfare state introduces expectations of individual responsiblity. *Sociology of Health and Illness, 32*(6), 930-947.

Mitcheson, J., & Cowley, S. (2003). Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies, 40*(4), 413-426.

Mold, A. (2010). Patient groups and the construction of the patient-consumer in Britain: an historical overview. *Journal of Social Policy, 39*(4), 505-521.

Moore, V. (2007). *Alcohol and drug service providers' perceptions of interagency collaboration with child welfare services.* Unpublished Dissertation, University of San Francisco, California.

Morrison, T. (1996). Partnership and collaboration: rhetoric and reality. *Child Abuse and Neglect, 20*(2), 127-140.

Moscovici, S. (1984). The Phenomenon of Social Representations (S. Rabinovitch, Trans.). In R. M. Farr & S. Moscovici (Eds.), *Social Representations* (pp. 3-70). Cambridge: Cambridge University Press.

Murray-Davis, B., Marshall, M., & Gordon, F. (2011). What do midwives think about interprofessional working and learning? *Midwifery, 27*(3), 376-381.

Musolf, G. R. (1992). Structure, institutions, power, and ideology: new directions within symbolic interactionism. *The Sociological Quarterly, 33*(2), 171-189.

Nancarrow, S. A., & Borthwick, A. M. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness, 27*(7), 897-919.

National Health and Hospitals Reform Commission. (2009). *A Healthier Future for All Australians: Final Report of the National Health and Hospitals Reform Commission*. Retrieved from www.health.gov.au/internet/yourhealth/publishing.nsf/Content/health-reform-overview.

National Health and Medical Research Council. (2010). *National Guidance on Collaborative Maternity Care*. Canberra: National Health and Medical Research Council.

National Health and Medical Research Council, & Australian Research Council. (2007). *National Statement on Ethical Conduct in Human Research*. Canberra: Australian Government.

National Health Performance Authority. (2013). nhpa: National Health Performance Authority. Retrieved 22nd August, 2013, from www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/home-1

National Preventive Health Taskforce. (2009). *Australia:The Healthiest Country by 2020*. Retrieved from www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphs-report-roadmap.

New South Wales Department of Health. (2009). *Supporting Families Early - SAFE START Strategic Policy*.

New South Wales Department of Health. (2011). *Child and Family Health Nursing: Professional Practice Framework 2011-2016*. Retrieved from www.health.nsw.gov.au/pubs/2011/pdf/cfhn_report_web.pdf.

Nicholson, D., Artz, S., & Armitage, A. (2000). Working relationships and outcomes in multidisciplinary collaborative practice settings. *Child and Youth Care Forum, 29*(1), 39-73.

Nursing and Midwifery Board of Australia. (2006a). *National Competency Standards for the Midwife*. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards.

Nursing and Midwifery Board of Australia. (2006b). *National Competency Standards for the Registered Nurse*. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards.

Nursing and Midwifery Board of Australia. (2007). *National Framework for The Development of Decision-making Tools for Nursing and Midwifery Practice*. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#decisionmakingframework.

Nursing and Midwifery Board of Australia. (2008a). *Code of Professional Conduct for Midwives in Australia*. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandrads.

Nursing and Midwifery Board of Australia. (2008b). *Code of Professional Conduct for Nurses in Australia*. Retrieved from www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards.

O'Connor, M. K., Netting, F. E., & Thomas, M. L. (2008). Grounded theory: managing the challenge for those facing institutional review board oversight. *Qualitative Inquiry, 14*(1), 28-45.

O'Flynn, J. (2008). Elusive appeal or aspirational ideal? The rhetoric and reality of the 'collaborative turn' in public policy. In J. O'Flynn & J. Wanna (Eds.), *Collaborative Governance: A New Era of Public Policy in Australia?* Canberra: ANU E Press.

O'Leary, Z. (2007). *The Social Science Jargon-Buster: The Key Terms You Need to Know*. London: SAGE Publications Limited.

Orchard, C. A. (2010). Persistent isolationist or collaborator? The nurses role in interprofessional collaborative practice. *Journal of Nursing Management, 18*(3), 248-257.

Page, L. (2003). One-to-one midwifery: restoring the "with woman" relationship in midwifery. *Journal of Midwifery and Women's Health, 48*(2), 119-125.

Palmer, G. R., & Short, S. D. (2010). *Health Care and Public Policy: An Australian Analysis* (4th ed.). Melbourne: Palgrave Macmillan.

Park, J., & Turnbull, A. (2003). Service integration in early intervention: Determining interpersonal and structural factors for it's success. *Infants and Young Children, 16*(1), 48-58.

Parsons, K. (2010). Exploring how Heideggerian philosophy underpins phenomenological research. *Nurse Researcher, 17*(4), 60-69.

Pascale, C.-M. (2010). Epistemology and the politics of knowledge. *The Sociological Review, 58*(s2), 154-165.

Patterson, K., & Logan-Sinclair, P. (2003). Continuum of care and the antenatal record in rural New South Wales. *Australian Journal of Rural Health, 11*(3), 110-115.

Penrod, J. (2007). Living with uncertainty: concept advancement. *Journal of Advanced Nursing, 57*(6), 658-667.

Peter, E., Spalding, K., Kenny, N., Conrad, P., McKeever, P., & Macfarlane, A. (2007). Neither seen nor heard: children and homecare policy in Canada. *Social Science and Medicine, 64*(8), 1624-1635.

Petri, L. (2010). Concept analysis of interdisciplinary collaboration. *Nursing Forum, 45*(2), 73-82.

Phillips, D., Thomas, K., Cox, H., Ricciardelli, L., Ogle, J., Love, V., et al. (2007). Factors that influence women's disclosures of substance use during pregnancy: a qualitative study of ten midwives and ten pregnant women. *Journal of Drug Issues, Spring*.

Powell, M., & Glendinning, C. (2002). Introduction. In C. Glendinning, M. Powell & K. Rummery (Eds.), *Partnerships, New Labour and the Governance of Welfare*. Bristol: The Policy Press.

Pratt, H. (1965). The doctor's view of the changing nurse-physician relationship. *Journal of Medical Education, 40*(8), 767-771.

Price, S., Doucet, S., & McGillis Hall, L. (2014). The historical social positioning of nursing and medicine: implications for career choice, early socialization and interprofessional collaboration. *Journal of Interprofessional Care, 28*(2), 103-109.

Prior, L. (2009). Commentary: from sick men and women, to patients, and thence to clients and consumers - the structuring of the 'patient' in the modern world. *International Journal of Epidemiology, 38*(3), 637-639.

Prosser, S. J., Miller, Y. D., Armanasco, A., Hennegan, J., Porter, J., & Thompson, R. (2013). *Findings from the Having a Baby in Queensland Survey, 2012*. Brisbane: Queensland Centre for Mothers and Babies.

Purcal, C., Muir, K., Putulny, R., Thomson, C., & Flaxman, S. (2011). Does partnership funding improve coordination and collaboration among early childhood services? - experiences from the Communities for Children programme. *Child and Family Social Work, 16*(4), 474-484.

Queensland Centre for Mothers and Babies. (2012). *Our Vision Our Work*. Brisbane.

Queensland Health. (2008). *Modelling Contemporary Nursing and Midwifery: A Framework for Shaping Professional Practice*. Brisbane: Queensland Government.

Queensland Health. (2010). *Model for Single Ethical Review of Multi-centre Research for Queensland Health*. Retrieved from http://www.health.qld.gov.au/ohmr/documents/serp_model_1004.pdf.

Queensland Health. (2011). Reporting Child Abuse and Neglect. Retrieved 6th August, 2013, from www.health.qld.gov.au/child-youth/webpages/rep-childabuse.asp

Queensland Health. (2013). *Blueprint for Better Healthcare in Queensland*. Retrieved from www.health.qld.gov.au/blueprint.

Reiger, K. M., & Lane, K. L. (2009). Working together: collaboration between midwives and doctors in public hospitals. *Australian Health Review, 33*(2), 315-324.

Richardson, L. (1994). Writing: A Method of Inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (1st ed.). Thousand Oaks: SAGE Publications Limited.

Rodriguez, C., & des Rivieres-Pigeon, C. (2007). A literature review on intergrated perinatal care. *International Journal of Integrated Care, 7*, 1-15.

Rollans, M., Schmied, V., Kemp, L., & Meade, T. (2013). Digging over the old ground: an Australian perspective of women's experience of psychosocial assessment and depression screening in pregnancy and following birth. *BioMed Central Women's Health, 13*(18).

Rose, L. E., Gerson, L., & Carbo, C. (2007). Transitional care for seriously mentally ill persons: A pilot study. *Archives of Psychiatric Nursing, 21*(6), 297-308.

Rowe, J., & Barnes, M. (2006). The role of child health nurses in enhancing mothering know-how. *Collegian, 13*(4), 22-26.

Rowe, J., Barnes, M., & Sutherns, S. (2013). Supporting maternal transition: continuity, coaching, and control. *The Journal of Perinatal Education, 22*(3), 145-155.

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative Interviewing: The Art of Hearing Data* (2nd ed.). California: SAGE Publications Limited.

Rushmer, R., & Pallis, G. (2002). Inter-professional working: the wisdom of integrated working and the disaster of blurred boundaries. *Public Money and Management, 23*(1), 59-66.

Salmon, P. (2010). The Work of Clinical Communication in Cancer Care. In R. Harris, N. Wathen & S. Wyatt (Eds.), *Configuring Health Consumers: Health Work and the Imperative of Personal Responsibility*. London: Palgrave Macmillan.

Salmon, P., & Hall, G. M. (2003). Patient empowerment and control: a psychological discourse in the service of medicine. *Social Science and Medicine, 57*(10), 1969-1980.

San Martin-Rodriguez, L., Beaulieu, M., D'Amour, D., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care, May*(Supplement 1), 132-147.

Sanson, A. (2006). *Some Features of Successful Collaborations*. Paper presented at the Longitudinal Studies Workshop. Retrieved from http://www.aracy.org.au/

Scamell, N. (2011). The swan effect in midwifery talk and practice: a tension between normality and the language of risk. *Sociology of Health and Illness, 33*(7), 987-1001.

Scheler, M. F. (1960/1980). *Problems of a Sociology of Knowledge* (M. S. Frings, Trans.). London: Routledge and Kegan Paul Ltd.

Schism or collaboration? (1947). *The American Journal of Nursing, 47*(3), 141-142.

Schlotfeldt, R. (1965). A mandate for nurses and physicians. *American Journal of Nursing, 65*(12).

Schmied, V., Donovan, J., Kruske, S., Kemp, L., Homer, C., & Fowler, C. (2011). Commonalities and challenges: a review of Australian state and territory maternity and child health policies. *Contemporary Nurse, 40*(1), 106-117.

Schmied, V., Mills, A., Kruske, S., Kemp, L., Folwer, C., & Homer, C. (2010). The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing, 19*(23/24), 3516-3526.

Schmitt, M. H. (2001). Collaboration improves the quality of care: methodological challenges and evidence from US health care research. *Journal of Interprofessional Care, 15*(1), 47-66.

Scott, D. (2005). Inter-organisational collaboration in family-centred practice: a framework for analysis and action. *Australian Social Work, 58*(2), 132-141.

Scott, D. (2009). Think child, think family. *Family Matters, 81*, 37-42.

Shepherd, M. L. (2011). Behind the scales: child and family health nurses taking care of women's emotional wellbeing. *Contemporary Nurse, 37*(2), 137-148.

Shields, L. (2010). Models of care: questioning family-centred care. *Journal of Clinical Nursing, 19*(17/18), 2629-2638.

Shonkoff, J. P. (2000). Science, policy, and practice: three cultures in search of a shared mission. *Child Development, 71*(1), 181-187.

Siraj-Blatchford, I., & Siraj-Blatchford, J. (2009). *Improving Developmental Outcomes for Children Through Effective Practice in Integrating Early Years Services*. London: Institute of Education, University of London.

Snelling, P. C. (2012). Saying something interesting about responsibility for health. *Nursing Philosophy, 13*(3), 161-178.

Socolar, R. (2002). Collaboration: The end of the means? *Journal of Public Health Management Practice, 8*(1), 34-35.

St Pierre, E. A. (2009). Afterword: Decentering Voice in Qualitative Inquiry. In A. Y. Jackson & L. A. Mazzei (Eds.), *Voice in Qualitative Inquiry: Challenging Conventional, Interpretive, and Critical Conceptions in Qualitative Research*. New York: Routledge.

Stapleton, S. R. (1998). Team-Building: making collaborative practice work. *Journal of Nurse-Midwifery, 43*(1), 12-18.

Steedman, P. H. (1991). On the Relations Between Seeing, Interpreting and Knowing. In F. Steier (Ed.), *Research and Reflexivity* (pp. 53-75). London: SAGE Publications Limited.

Stefaniak, K. (1998). *Nurses Collaborating with Other Nurses: When All Else Fails.* University of Kentucky, Lexington.

Stern, P. N. (2007). On Solid Ground: Essential Properties for Growing Grounded Theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory*. London: SAGE Publications Limited.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly, 63*(3), 224-237.

Stets, J. E., & Cast, A. D. (2007). Resources and identity verification from an identity theory perspective. *Sociological Perspectives, 50*(4), 517-543.

Stevens, T., & McCourt, C. (2002). One-to-one midwifery practice part 3: meaning for midwives. *British Journal of Midwifery, 10*(2), 111-115.

Stokes, R., & Hewitt, J. P. (1976). Aligning Actions. *American Sociological Review, 41*(5), 838-849.

Stone, G. P. (1962). Appearance and the Self. In A. M. Rose (Ed.), *Human Behavior and Social Processes: An Interactionist Approach*. London: Routledge and Kegan Paul.

Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). London: SAGE Publications Limited.

Stryker, S., & Burke, P. J. (2000). The past, present, and future of an identity theory. *Social Psychology Quarterly, 63*(4).

Stryker, S., & Serpe, R. T. (1982). Commitment, Identity Salience, and Role Behaviour: Theory and Research Example. In W. I. Ickles. & E.S.Knowles. (Eds.), *Personality, Roles and Social Behavior* (pp. 199-218). New York: Springer-Verlag Inc.

Styles, M. M. (1984). Reflections on collaboration and unification. *IMAGE: The Journal of Nursing Scholarship, 16*(1), 21-23.

Sullivan, T. J. (1998). Collaboration: A Health Care Imperative

Sundell, K., & Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: a 3-year follow up. *Child Abuse and Neglect, 28*(3), 267-287.

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care, 23*(1), 41-51.

Tajfel, H. (1969). Cognitive aspects of prejudice. *Journal of Social Issues, 25*(4), 79-97.

Tajfel, H. (1978). Social categorization, social identity and social comparison. In H. Tajfel (Ed.), *Differentiation Between Social Groups: Studies in the Social Psychology of Intergroup Relations* (pp. 61 - 76). London: Academic Press Inc. Ltd.

Temkin-Greener, H. (1983). Interprofessional perspectives on teamwork in health care: a case study. *The Milbank Memorial Fund Quarterly. Health and Society, 61*(4), 641-658.

The Allen Consulting Group. (2008). *Inverting the Pyramid: Enhancing Systems for Protecting Children*. Melbourne.

The Allen Consulting Group. (2010). *Final Guidance Manual for the Common Approach for Identifying and Responding Early to Indicators of Need.* Canberra: Allen Consulting Group Pty Ltd.

The Department of Health. (2013). Chronic Disease Management (CDM) Medicare Items. Retrieved 10th February, 2014

Thomas, W. I. (1923). *The Unadjusted Girl* (Vol. No. 4; Criminal Science Monograph). Boston: Little, Brown and Company.

Thompson, D., Socolar, R., Brown, L., & Haggerty, J. (2002). Interagency collaboration in seven North Carolina counties. *Journal of Public Health Management Practice, 8*(5), 55-64.

Thompson, M. (1997). Borders, boundaries and balloons: conceptual and professional issues in defining the scope of practice. *Collegian, 4*(1), 32-36.

Thompson, R. E., Kildea, S. V., Barclay, L. M., & Kruske, S. (2011). An account of significant events influencing Australian breastfeeding practice over the last 40 years. *Women and Birth, 24*(3), 97-104.

Todahl, J. L., Linville, D., Smith, T. E., Barnes, M. F., & Miller, J. K. (2006). A qualitative study of collaborative health care in a primary care setting. *Families, Systems and Health, 24*(1), 45-64.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspectives of family-centred care: a qualitative study. *Journal of Clinical Nursing, 21*(17-18), 2477-2487.

Valentine, K., Fisher, K., & Thomson, C. (2006). Making integration happen: the Families First policy experience. *Child Abuse Review, 15*(6), 414-428.

van Emden, D. M. D., Wynnand, J. G., & Berns, M. P. H. (1999). Transition of care: an evaluation of the role of the discharge liaison nurse in the Netherlands. *Journal of Advanced Nursing, 30*(5), 1186-1194.

van Eyk, H., & Baum, F. (2002). Learning about interagency collaboration: trialling collaborative projects between hospital and community health services. *Health and Social Care in the Community, 10*(4), 262-269.

van Langenhove, L., & Harre, R. (1999). Introducing Positioning Theory. In R. Harre. & L. vanLangenhove. (Eds.), *Positioning Theory: Moral Contexts of Intentional Action*. Oxford: Blackwell Publishers Limited.

Veinot, T. (2010). Power to the Patient? A Critical Examination of Patient Empowerment Discourses. In R. Harris, N. Wathen & S. Wyatt (Eds.), *Configuring Health Consumers: Health Work and the Imperative of Personal Responsibility*. London: Palgrave Macmillan.

Wagner, H. R. (Ed.). (1970). *Alfred Schutz on Phenomenology and Social Relations: Selected Writings*. Chicago: The University of Chicago Press.

Walter, U. M., & Petr, C. G. (2000). A template for family-centered interagency collaboration. *Families in Society, 81*(5), 494-503.

Warde, A. (1994). Consumers, Identity and Belonging:Reflections on Some Theses of Zygmunt Bauman. In R. Keat, N. Whiteley & N. Abercrombie (Eds.), *The Authority of the Consumer*. London: Routledge.

Warshay, L. H. (1962). Breadth of Perspective. In A. M. Rose (Ed.), *Human Behavior and Social Process: An Interactionist Approach*. London: Routledge & Kegan Paul Limited.

Waterworth, S., & Luker, K. A. (1990). Reluctant collaborators: do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing, 15*(8), 971-976.

Weed, L. L. (1968). Medical records that guide and teach. *The New England Journal of Medicine, 278*(11), 593-600.

Weiss, S. J. (1985). The influence of discourse on collaboration among nurses, physicians, and consumers. *Research in Nursing and Health, 8*(1), 49-59.

Wigert, H., Johansson, R., Berg, M., & Hellstrom, A. L. (2006). Mothers' experiences of having their newborn child in a neonatal intensive care unit. *Scandinavian Journal of Caring Sciences, 20*(1), 35-41.

Wiggins, M. S. (2008). The partnership care delivery model: an examination of the core concept and the need for a new model of care. *Journal of Nursing Management, 16*(5), 629-638.

Wikler, D. (2002). Personal and social responsibility for health. *Ethics and International Affairs, 16*(2), 47-55.

Williams, M. A. (1964). The myths and assumptions about team nursing. *Nursing Forum, 3*(4), 61-73.

Williams, P. (2011). The life and times of the boundary spanner. *Journal of Integrated Care, 1*(3), 26-33.

Williams, P., & Sullivan, H. (2009). Faces of integration. *International Journal of Integrated Care, 9*, 1-13.

Wilson, H. V. (2001). Power and partnership: a critical analysis of the surveillance discourses of child health nurses. *Journal of Advanced Nursing, 36*(2), 294-301.

Wilson, V., & Pirrie, A. (2000). *Multidisciplinary Teamworking Indicators of Good Practice*. Retrieved from www.scre.ac.uk.

Windsor, C., Douglas, C., & Harvey, T. (2011). Nursing and competencies - a natural fit: the politics of skill/competency formation in nursing. *Nursing Inquiry, 19*(3), 213-222.

World Health Organisation. (2003). *Social Determinants of Health: The Solid Facts* (2nd ed.). Copenhagen: World Health Organisation.

World Health Organisation. (2010). *Framework for Action on Interprofessional Education and Collaborative Practice*. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf.

Wyatt, S., Harris, R., & Wathen, N. (2010). Health(y) Citizenship: Technology, Work and Narratives of Responsibility. In R. Harris, N. Wathen & S. Wyatt (Eds.), *Configuring Health Consumers: Health Work and the Imperative of Personal Responsibility*. London: Palgrave Macmillan.

Appendices

Appendix A Consent and Information Sheets

Information Sheet to Women Participants

Queensland University of Technology

Queensland Government

Your View is Important

If your newborn has spent more than 48 hours in the Neonatal Nursery we are interested in your view of how you experienced care in between leaving the maternity hospital and contact with the community child health service.

I would appreciate the opportunity to discuss this research with you further.

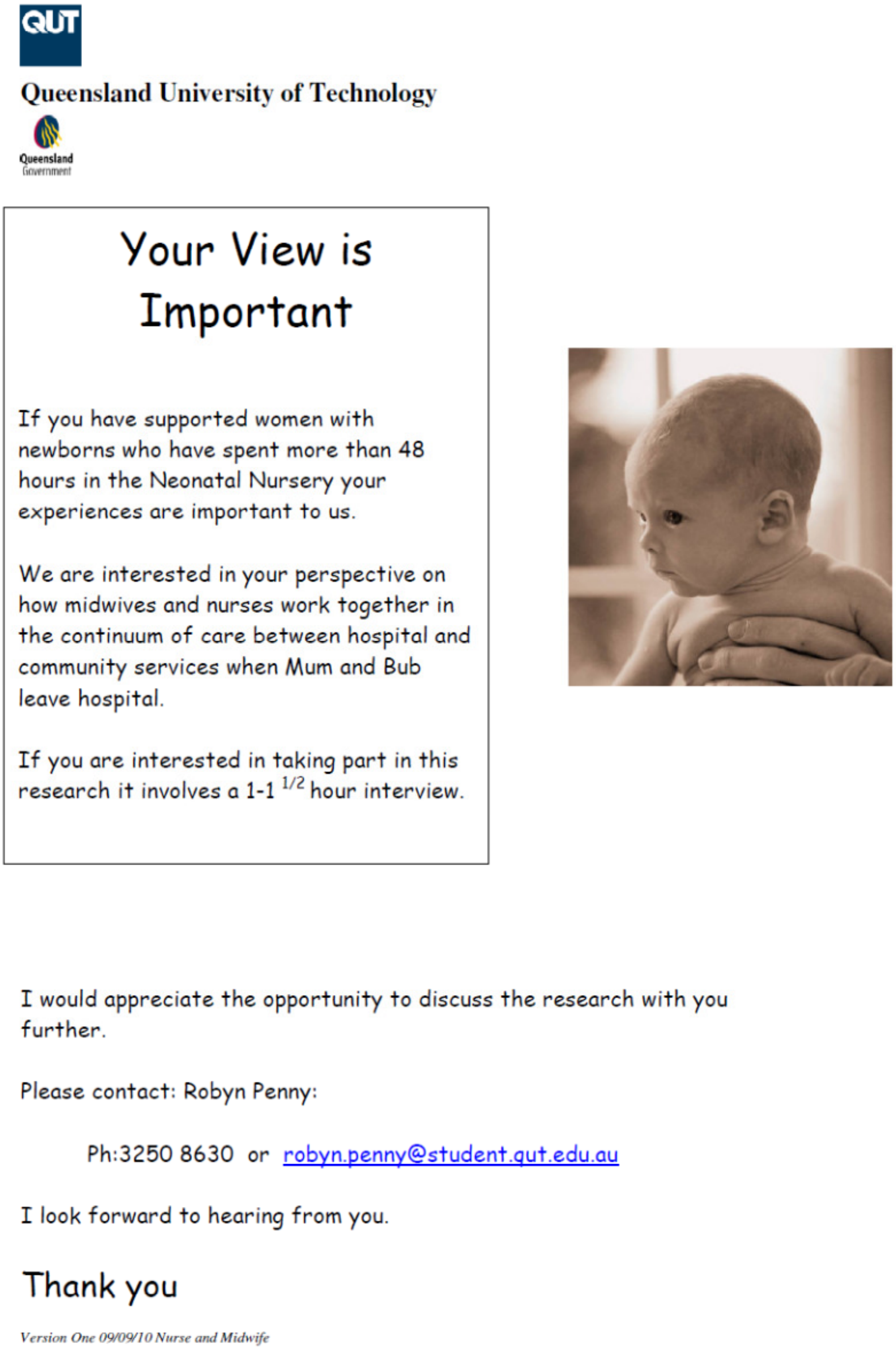
If you are interested in taking part in an interview please contact me:

Robyn Penny: 3250 8630 or
robyn.penny@student.qut.edu.au

Thank You

Version One: 09/09/10 : Women

Information Sheet to Nurse and Midwife Participants



Queensland University of Technology

Queensland Government

Your View is Important

If you have supported women with newborns who have spent more than 48 hours in the Neonatal Nursery your experiences are important to us.

We are interested in your perspective on how midwives and nurses work together in the continuum of care between hospital and community services when Mum and Bub leave hospital.

If you are interested in taking part in this research it involves a 1-1 $^{1/2}$ hour interview.

I would appreciate the opportunity to discuss the research with you further.

Please contact: Robyn Penny:

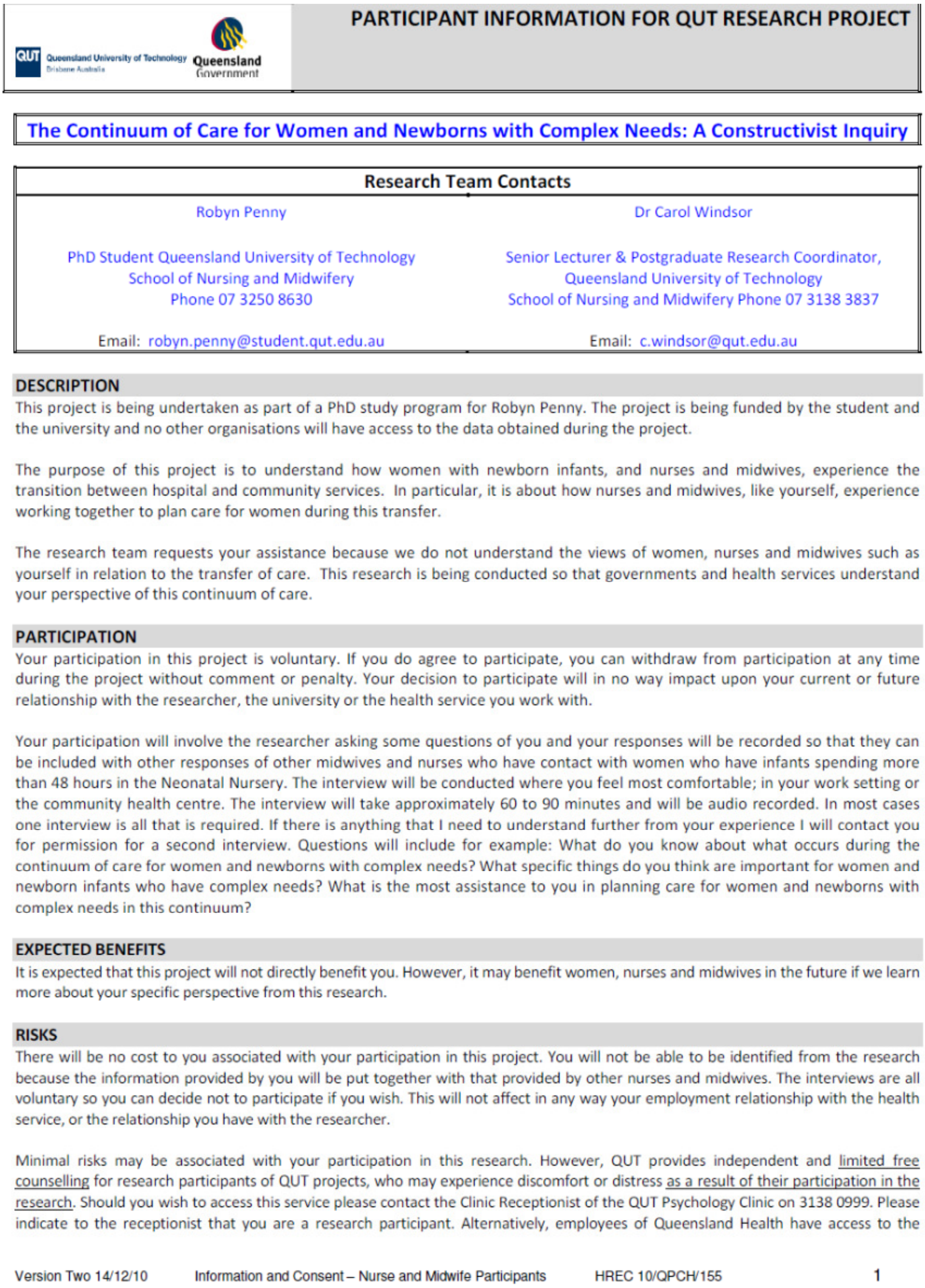
Ph:3250 8630 or robyn.penny@student.qut.edu.au

I look forward to hearing from you.

Thank you

Version One 09/09/10 Nurse and Midwife

Consent Form Nurse and Midwife Participants



PARTICIPANT INFORMATION FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

DESCRIPTION

This project is being undertaken as part of a PhD study program for Robyn Penny. The project is being funded by the student and the university and no other organisations will have access to the data obtained during the project.

The purpose of this project is to understand how women with newborn infants, and nurses and midwives, experience the transition between hospital and community services. In particular, it is about how nurses and midwives, like yourself, experience working together to plan care for women during this transfer.

The research team requests your assistance because we do not understand the views of women, nurses and midwives such as yourself in relation to the transfer of care. This research is being conducted so that governments and health services understand your perspective of this continuum of care.

PARTICIPATION

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with the researcher, the university or the health service you work with.

Your participation will involve the researcher asking some questions of you and your responses will be recorded so that they can be included with other responses of other midwives and nurses who have contact with women who have infants spending more than 48 hours in the Neonatal Nursery. The interview will be conducted where you feel most comfortable; in your work setting or the community health centre. The interview will take approximately 60 to 90 minutes and will be audio recorded. In most cases one interview is all that is required. If there is anything that I need to understand further from your experience I will contact you for permission for a second interview. Questions will include for example: What do you know about what occurs during the continuum of care for women and newborns with complex needs? What specific things do you think are important for women and newborn infants who have complex needs? What is the most assistance to you in planning care for women and newborns with complex needs in this continuum?

EXPECTED BENEFITS

It is expected that this project will not directly benefit you. However, it may benefit women, nurses and midwives in the future if we learn more about your specific perspective from this research.

RISKS

There will be no cost to you associated with your participation in this project. You will not be able to be identified from the research because the information provided by you will be put together with that provided by other nurses and midwives. The interviews are all voluntary so you can decide not to participate if you wish. This will not affect in any way your employment relationship with the health service, or the relationship you have with the researcher.

Minimal risks may be associated with your participation in this research. However, QUT provides independent and limited free counselling for research participants of QUT projects, who may experience discomfort or distress as a result of their participation in the research. Should you wish to access this service please contact the Clinic Receptionist of the QUT Psychology Clinic on 3138 0999. Please indicate to the receptionist that you are a research participant. Alternatively, employees of Queensland Health have access to the

Employee Assistance Scheme if required.

CONFIDENTIALITY

All comments and responses will be treated confidentially and will be made anonymous when transcribed. The names of individual persons or services are not required in any of the responses. You will not need to verify the information from the recorded interviews prior to inclusion in the research findings. The interviews will not be used for any purpose other than this research. The researcher and research supervisors will be the only people who will have access to the recorded interviews. While this research may be published, participants and responses will remain anonymous.

CONSENT TO PARTICIPATE

We would like to ask you to sign the written consent form attached to confirm your agreement to participate in this research.

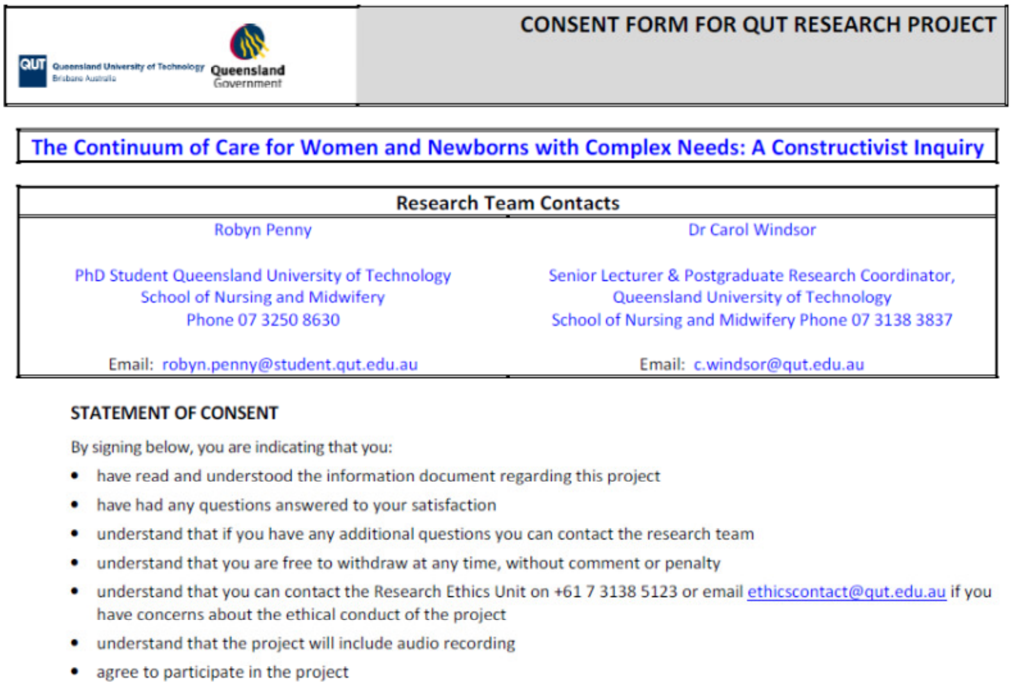
QUESTIONS / FURTHER INFORMATION ABOUT THE PROJECT

Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

CONCERNS / COMPLAINTS REGARDING THE CONDUCT OF THE PROJECT

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au. The Research Ethics Unit is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

Thank you for helping with this research project. Please keep this sheet for your information.



CONSENT FORM FOR QUT RESEARCH PROJECT

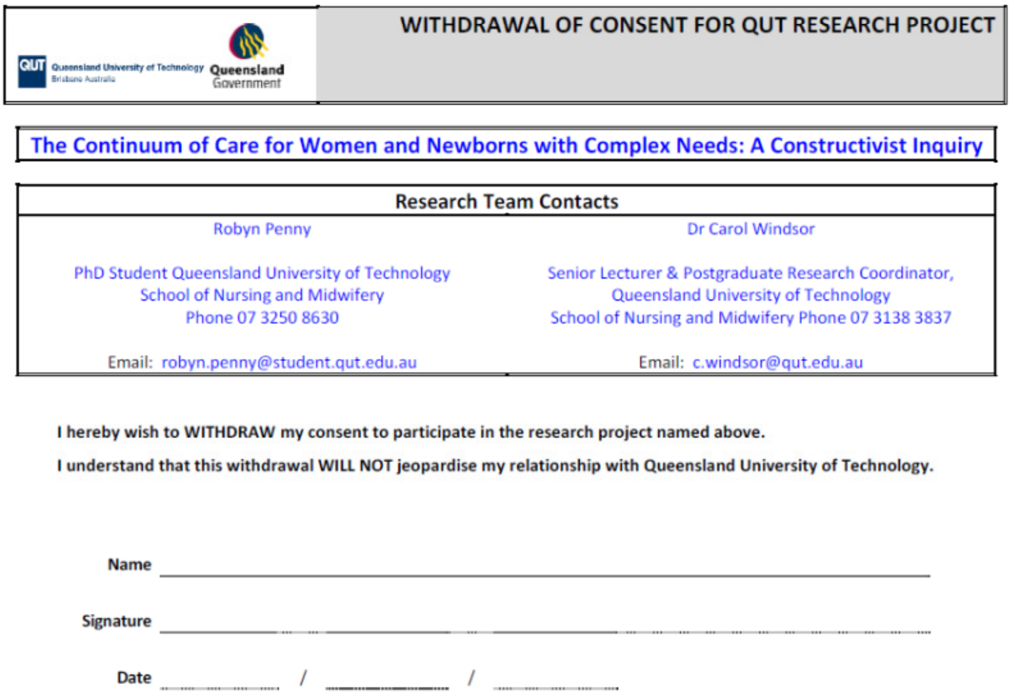
The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts	
Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

STATEMENT OF CONSENT

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions you can contact the research team
- understand that you are free to withdraw at any time, without comment or penalty
- understand that you can contact the Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project
- understand that the project will include audio recording
- agree to participate in the project



WITHDRAWAL OF CONSENT FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

I hereby wish to WITHDRAW my consent to participate in the research project named above.

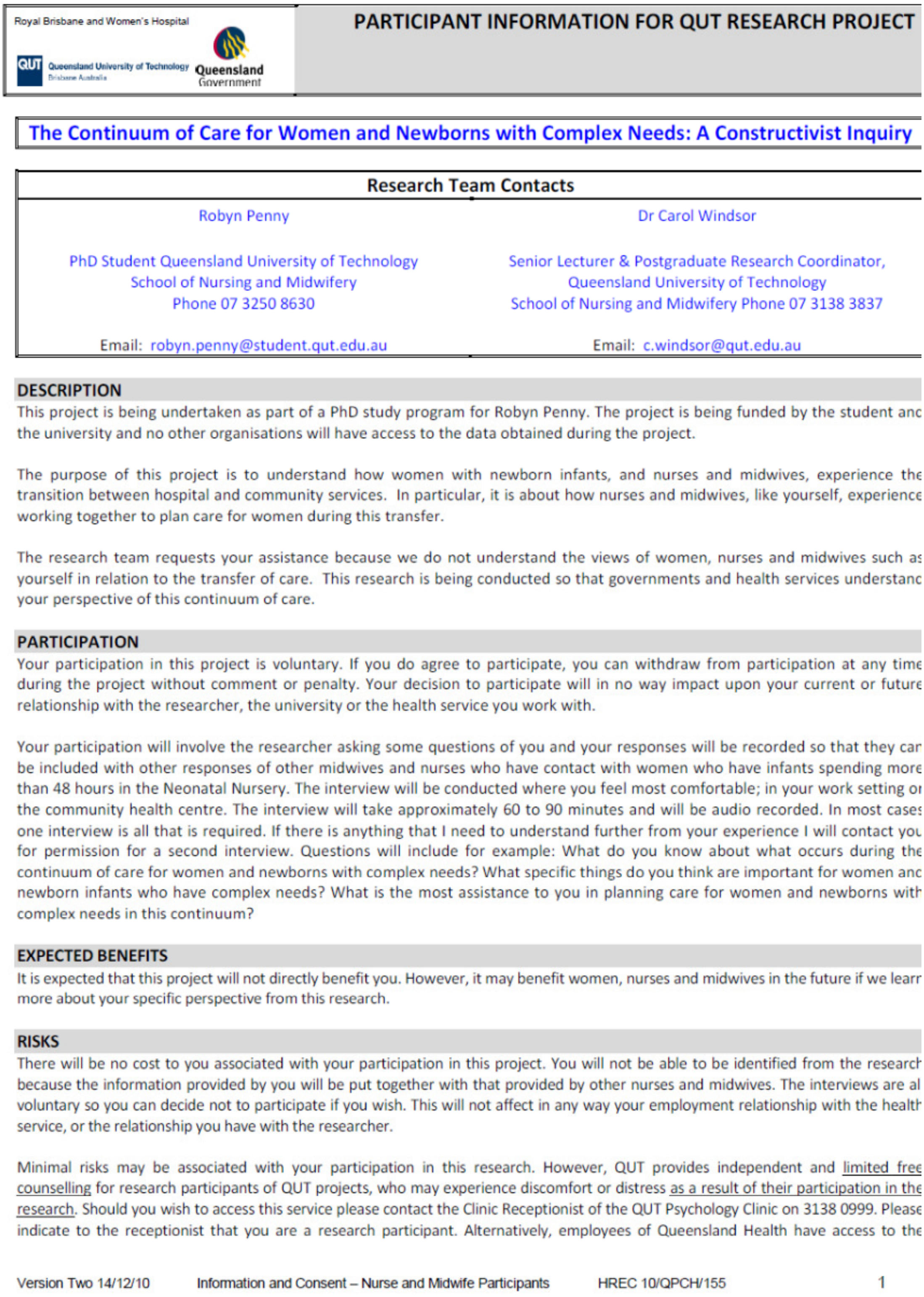
I understand that this withdrawal WILL NOT jeopardise my relationship with Queensland University of Technology.

Name ______________________________

Signature ______________________________

Date ________ / ________ / ________

Consent Form Nurse and Midwife Participants Version Two



Royal Brisbane and Women's Hospital

QUT Queensland University of Technology Brisbane Australia

Queensland Government

PARTICIPANT INFORMATION FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

DESCRIPTION

This project is being undertaken as part of a PhD study program for Robyn Penny. The project is being funded by the student and the university and no other organisations will have access to the data obtained during the project.

The purpose of this project is to understand how women with newborn infants, and nurses and midwives, experience the transition between hospital and community services. In particular, it is about how nurses and midwives, like yourself, experience working together to plan care for women during this transfer.

The research team requests your assistance because we do not understand the views of women, nurses and midwives such as yourself in relation to the transfer of care. This research is being conducted so that governments and health services understand your perspective of this continuum of care.

PARTICIPATION

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with the researcher, the university or the health service you work with.

Your participation will involve the researcher asking some questions of you and your responses will be recorded so that they can be included with other responses of other midwives and nurses who have contact with women who have infants spending more than 48 hours in the Neonatal Nursery. The interview will be conducted where you feel most comfortable; in your work setting or the community health centre. The interview will take approximately 60 to 90 minutes and will be audio recorded. In most cases one interview is all that is required. If there is anything that I need to understand further from your experience I will contact you for permission for a second interview. Questions will include for example: What do you know about what occurs during the continuum of care for women and newborns with complex needs? What specific things do you think are important for women and newborn infants who have complex needs? What is the most assistance to you in planning care for women and newborns with complex needs in this continuum?

EXPECTED BENEFITS

It is expected that this project will not directly benefit you. However, it may benefit women, nurses and midwives in the future if we learn more about your specific perspective from this research.

RISKS

There will be no cost to you associated with your participation in this project. You will not be able to be identified from the research because the information provided by you will be put together with that provided by other nurses and midwives. The interviews are al voluntary so you can decide not to participate if you wish. This will not affect in any way your employment relationship with the health service, or the relationship you have with the researcher.

Minimal risks may be associated with your participation in this research. However, QUT provides independent and limited free counselling for research participants of QUT projects, who may experience discomfort or distress as a result of their participation in the research. Should you wish to access this service please contact the Clinic Receptionist of the QUT Psychology Clinic on 3138 0999. Please indicate to the receptionist that you are a research participant. Alternatively, employees of Queensland Health have access to the

Version Two 14/12/10 Information and Consent – Nurse and Midwife Participants HREC 10/QPCH/155 1

Employee Assistance Scheme if required.

CONFIDENTIALITY

All comments and responses will be treated confidentially and will be made anonymous when transcribed. The names of individual persons or services are not required in any of the responses. You will not need to verify the information from the recorded interviews prior to inclusion in the research findings. The interviews will not be used for any purpose other than this research. The researcher and research supervisors will be the only people who will have access to the recorded interviews. While this research may be published, participants and responses will remain anonymous.

CONSENT TO PARTICIPATE

We would like to ask you to sign the written consent form attached to confirm your agreement to participate in this research.

QUESTIONS / FURTHER INFORMATION ABOUT THE PROJECT

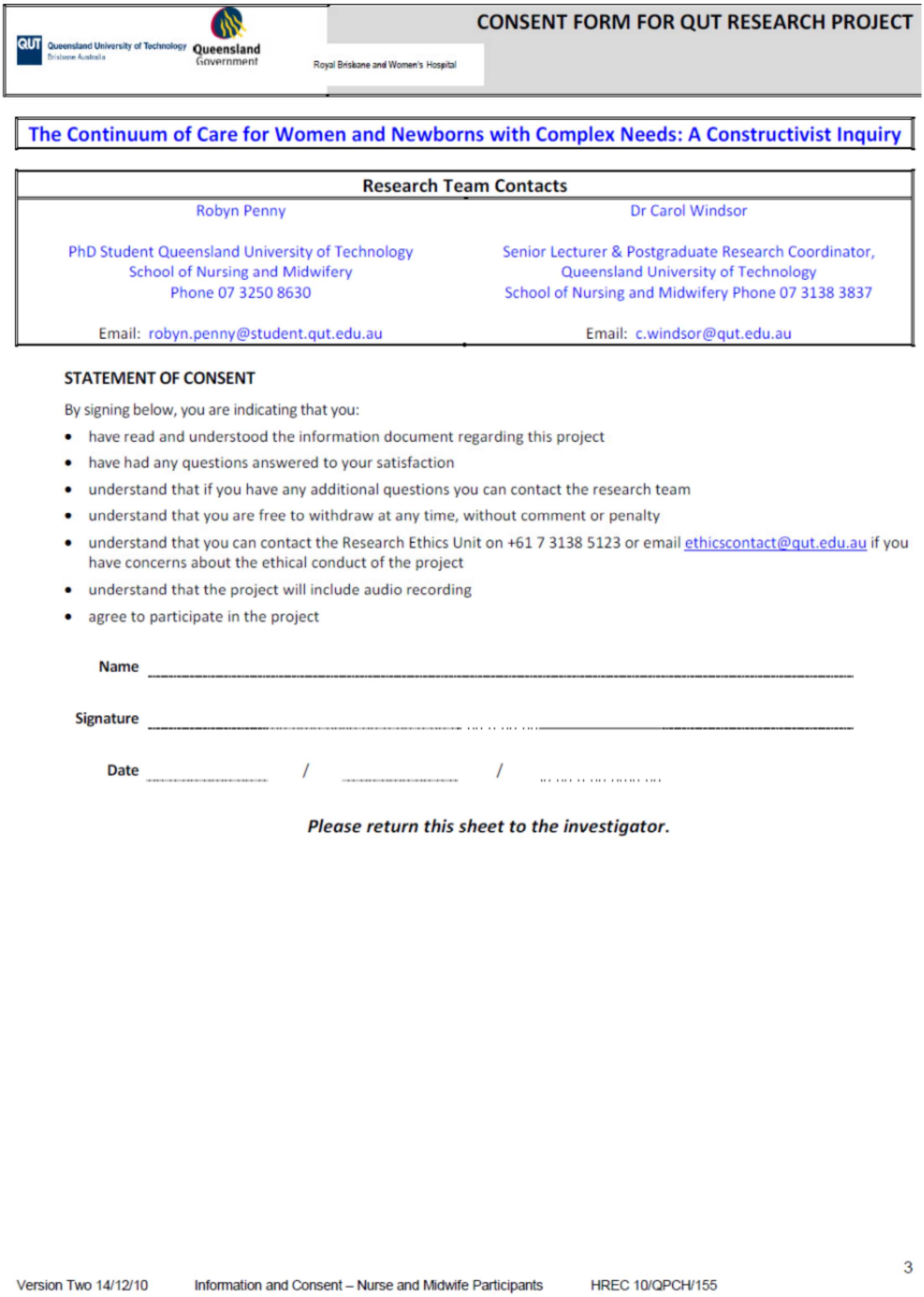
Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

CONCERNS / COMPLAINTS REGARDING THE CONDUCT OF THE PROJECT

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au. The Research Ethics Unit is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

This study has been reviewed by The Prince Charles Hospital Human Research Ethics Committee on behalf of the Royal Brisbane and Women's Hospital. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make an independent complaint, you can contact the Research Support Officer, Royal Brisbane & Women's Hospital, Herston, Qld 4029 or telephone (07) 3636 8579.

Thank you for helping with this research project. Please keep this sheet for your information.



QUT Queensland University of Technology Brisbane Australia
Queensland Government
Royal Brisbane and Women's Hospital

CONSENT FORM FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts	
Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

STATEMENT OF CONSENT

By signing below, you are indicating that you:

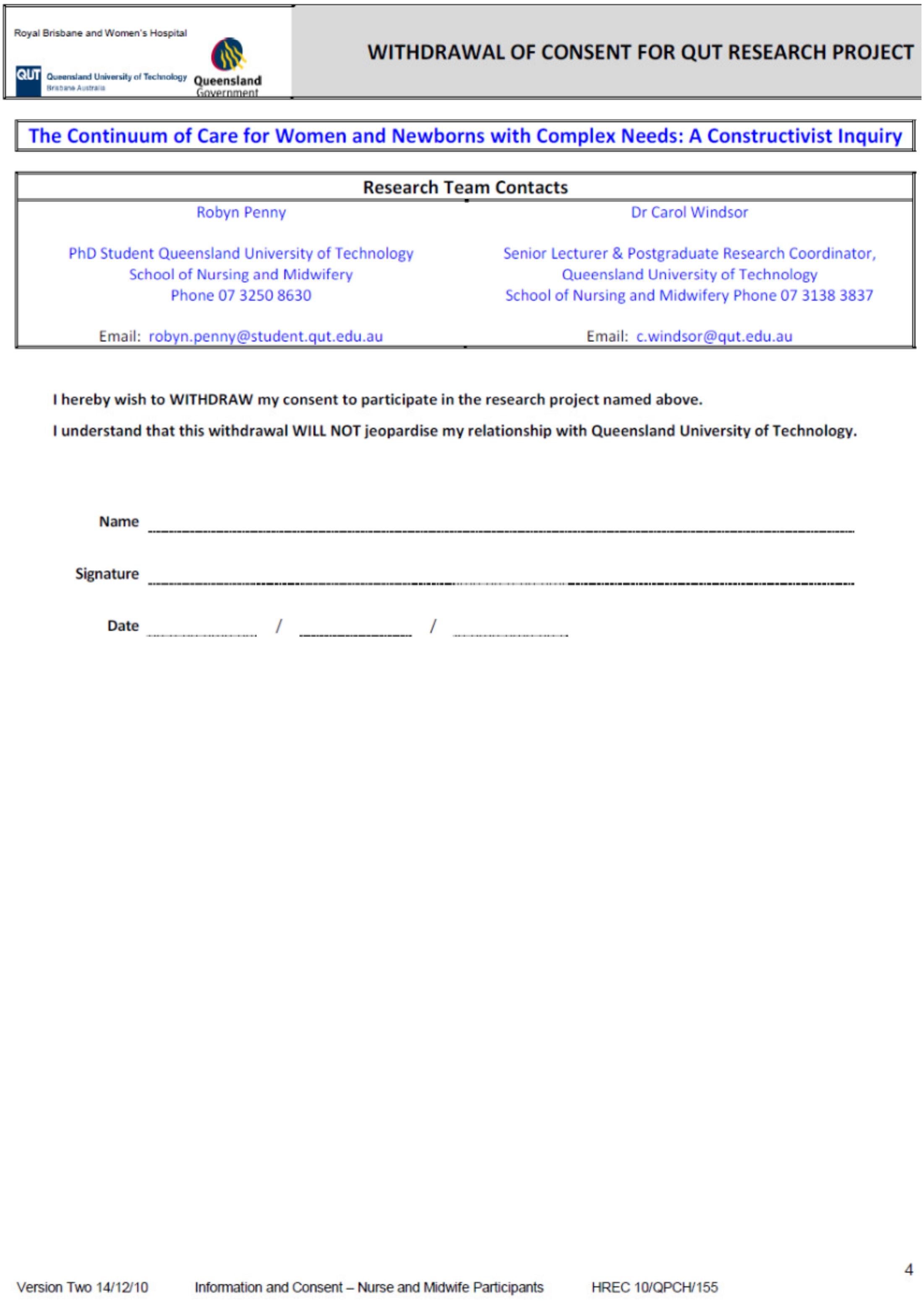
- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions you can contact the research team
- understand that you are free to withdraw at any time, without comment or penalty
- understand that you can contact the Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project
- understand that the project will include audio recording
- agree to participate in the project

Name ____

Signature ____

Date __________ / __________ / __________

Please return this sheet to the investigator.



Royal Brisbane and Women's Hospital

Queensland University of Technology
Brisbane Australia

Queensland Government

WITHDRAWAL OF CONSENT FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts	
Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

I hereby wish to WITHDRAW my consent to participate in the research project named above.

I understand that this withdrawal WILL NOT jeopardise my relationship with Queensland University of Technology.

Name ____

Signature ____

Date __________ / __________ / __________

4

Version Two 14/12/10 Information and Consent – Nurse and Midwife Participants HREC 10/QPCH/155

Consent Form Women Participants

Queensland University of Technology
Brisbane Australia

Queensland Government

PARTICIPANT INFORMATION FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny	Dr Carol Windsor
PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

DESCRIPTION

This project is being undertaken as part of a PhD program for Robyn Penny. The project is being funded by the student and the university and no other organisations will have access to the data obtained during the project.

The purpose of this project is to understand how women with newborn infants experience the transition between the hospital and the return home. In particular, it is about how women like yourself experience the transfer of care to the community health services so you may receive ongoing support.

The research team requests your assistance because we do not understand the views of women such as yourself in relation to the transfer of care. This research is being conducted so that governments and health services understand what is needed for ongoing support when your newborn has spent time in the Neonatal Nursery. This includes your views about how services work together to provide this ongoing support.

PARTICIPATION

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with the health service or staff you have been involved with.

Your participation will involve the researcher visiting you at home after you have been home from hospital for a short time to hear of your experiences. The interview will take place where you feel most comfortable and so another location can be arranged for you such as the local child health clinic. The researcher will have some interview questions to ask you and your responses will be audio recorded so that they can be included with the responses of other women who have also had newborns in the Neonatal Nursery. The interview will take approximately 60 to 90 minutes. In most cases one interview is all that is required. If there is anything further that I need to understand from your experience I will contact you for permission for another interview. If your baby has needs during the interview we will allow time for you to attend to these. Questions will include for example: What was arranged for you when you left hospital? What were your specific needs at this time? Tell me about what happened when you were getting ready to go home from hospital? What was important or not important about meeting up with child health services after you left hospital?

EXPECTED BENEFITS

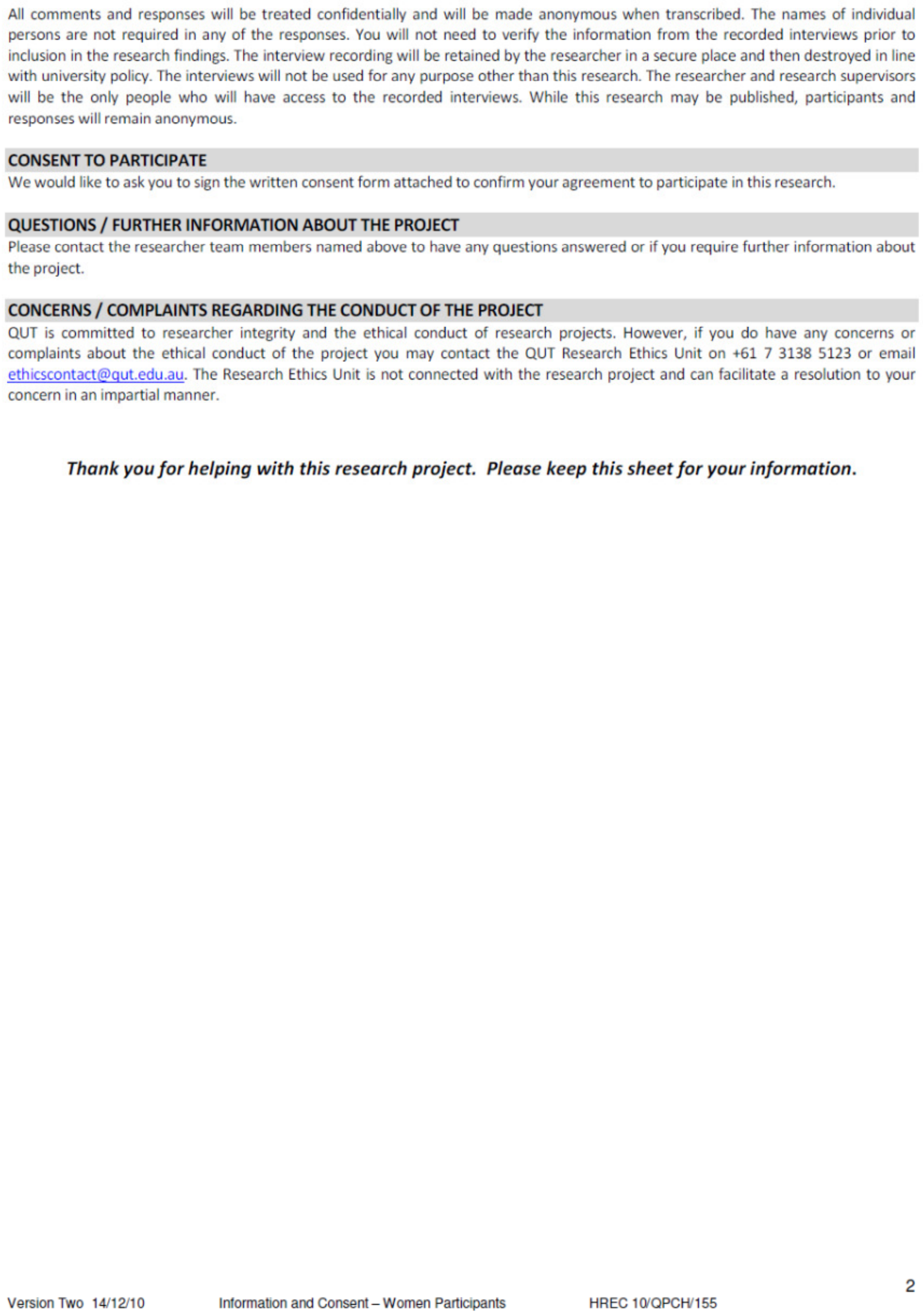
It is expected that this project will not directly benefit you. However, it may benefit women with experiences such as yours in the future if we learn more about your specific experiences from this research.

RISKS

There will be no cost to you associated with your participation in this project. You will not be able to be identified from the research because the information provided by you will be put together with that provided by other women. The interviews are all voluntary so that you can decide not to participate if you wish and this will not change in any way the care you receive from the health service.

Minimal risks may be associated with your participation in this research. However, QUT provides independent and limited free counselling for research participants of QUT projects, who may experience discomfort or distress as a result of their participation in the research. Should you wish to access this service please contact the Clinic Receptionist of the QUT Psychology Clinic on 3138 0999. Please indicate to the receptionist that you are a research participant. Alternatively, there are social workers and psychologists available free within Queensland Health if any distress relating to parenting issues arises as a result of this research.

CONFIDENTIALITY



All comments and responses will be treated confidentially and will be made anonymous when transcribed. The names of individual persons are not required in any of the responses. You will not need to verify the information from the recorded interviews prior to inclusion in the research findings. The interview recording will be retained by the researcher in a secure place and then destroyed in line with university policy. The interviews will not be used for any purpose other than this research. The researcher and research supervisors will be the only people who will have access to the recorded interviews. While this research may be published, participants and responses will remain anonymous.

CONSENT TO PARTICIPATE

We would like to ask you to sign the written consent form attached to confirm your agreement to participate in this research.

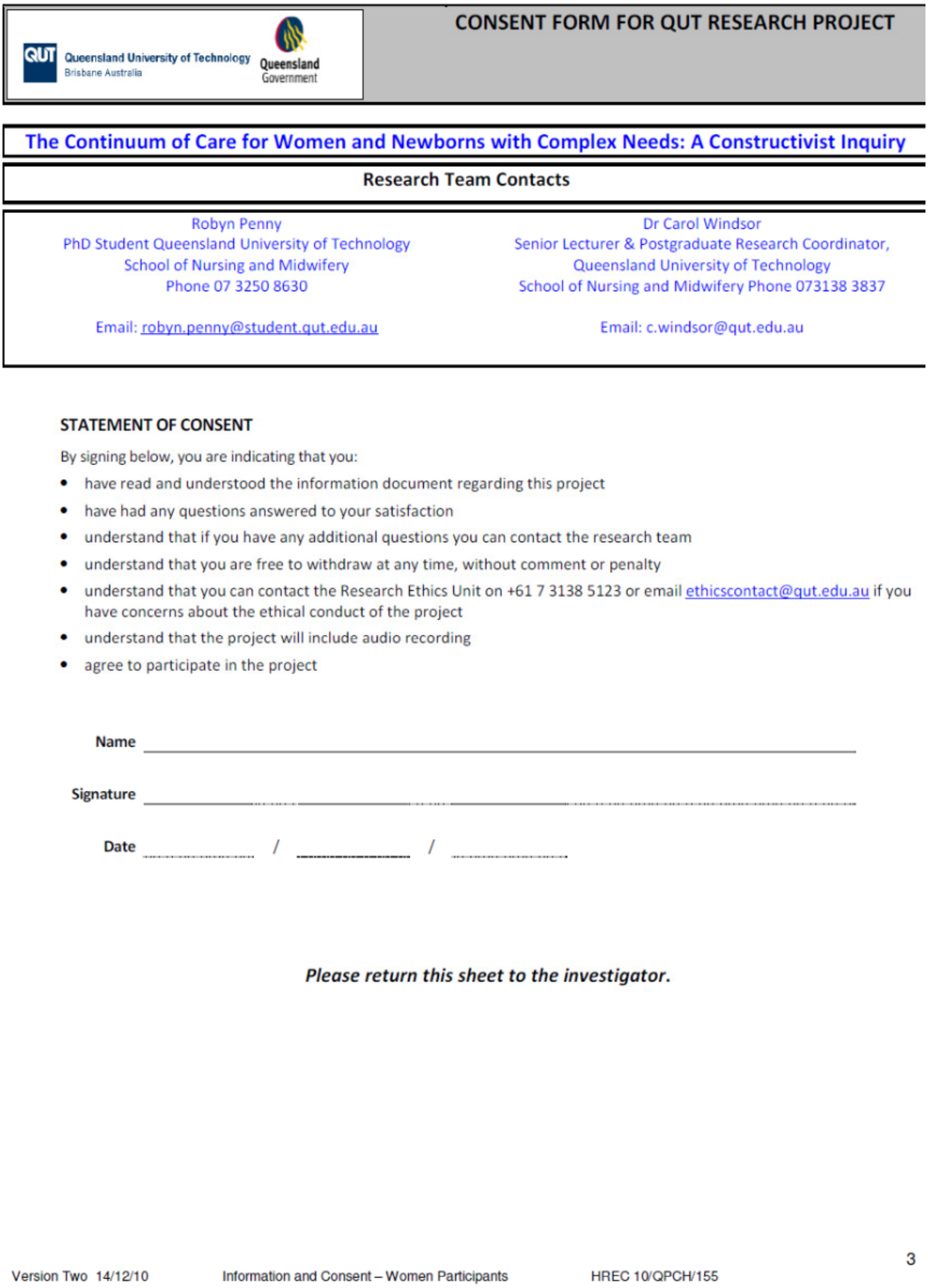
QUESTIONS / FURTHER INFORMATION ABOUT THE PROJECT

Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

CONCERNS / COMPLAINTS REGARDING THE CONDUCT OF THE PROJECT

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au. The Research Ethics Unit is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

Thank you for helping with this research project. Please keep this sheet for your information.



Queensland University of Technology
Brisbane Australia

Queensland Government

CONSENT FORM FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630	Dr Carol Windsor Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 073138 3837
Email: robyn.penny@student.qut.edu.au	Email: c.windsor@qut.edu.au

STATEMENT OF CONSENT

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions you can contact the research team
- understand that you are free to withdraw at any time, without comment or penalty
- understand that you can contact the Research Ethics Unit on +61 7 3138 5123 or email ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project
- understand that the project will include audio recording
- agree to participate in the project

Name ____________________

Signature ____________________

Date ________ / ________ / ________

Please return this sheet to the investigator.

Queensland University of Technology
Brisbane Australia

Queensland Government

WITHDRAWAL OF CONSENT FOR QUT RESEARCH PROJECT

The Continuum of Care for Women and Newborns with Complex Needs: A Constructivist Inquiry

Research Team Contacts

Robyn Penny PhD Student Queensland University of Technology School of Nursing and Midwifery Phone 07 3250 8630 Email: robyn.penny@student.qut.edu.au	Dr Carol Windsor Senior Lecturer & Postgraduate Research Coordinator, Queensland University of Technology School of Nursing and Midwifery Phone 07 3138 3837 Email: c.windsor@qut.edu.au

I hereby wish to WITHDRAW my consent to participate in the research project named above.

I understand that this withdrawal WILL NOT jeopardise my relationship with Queensland University of Technology.

Name ______________________________

Signature ______________________________

Date ________ / ________ / ________

Appendix B1 Interview Guide – Community Nurse and Midwife Participants

Opening Questions:

Can you tell me about your typical day in your role, particularly in relation to visiting women with infants with complex needs when they are just home from the hospital?
Tell me about what happens when information is received about women with infants who have complex needs who are coming home from hospital?
Tell me about the communication processes that occur.
What things are in place that guide or inform you in your role?
Why does it happen like this?
How would you describe it to someone who was coming new to the role?

Intermediate Questions:

What does the concept 'complex' mean to you?
What are the most important aspects about contacting women with complex needs when they come home?
What things do you need to know to plan ongoing care when women have infants with complex needs?
Can you tell me about your experiences with maternity and neonatal services?
Do you have much contact or communication with the hospital staff?
What specific things do you think are important for women with infants who have complex needs?
What do you know about what occurs when women with complex needs leave hospital?
How did you learn to manage the processes?
To what extent do you have to negotiate the processes of transfer of care?
What would it be like when women with complex needs can come home from hospital successfully and safely?
What is the most assistance to you in planning care for women with complex needs coming home?
Who are some of the other people who work with you to plan care for women with complex needs?

Ending Questions:

If there is something you would like to happen differently for women coming home with infants with complex needs what would it be?
What would you like to see in place (better structures) that would make this job work better?
Is there anything else you think I should know to understand what it is like for you in your role?
Is there anything else you think I should know about how maternity/neonatal services and child health services work together?
Some people call this work collaboration, what do you call it?
Is there anything you would like to ask me?

Appendix B2 Interview Guide – Hospital Nurse and Midwife Participants

Opening Questions:

Can you tell me about your typical day in your role, particularly in relation to preparing women with infants with complex needs to go home from hospital?
Tell me about the communication processes that occur?
What things are in place that guide or inform you in your role?
Why is it happening like this?
How would you describe it to someone who was coming new to the role?

Intermediate Questions:

What has your experience been communicating or working with child health?
What do you know about what occurs after women with infants who have complex needs go home from hospital?
Do you receive feedback from community nurses or talk with the community staff?
What does the concept ‘complex’ mean to you?
How did you learn to manage the role and processes?
To what extent do you have to negotiate the processes of discharge planning?
Are there structures that support you in this complex role?
What are the most important aspects to you about preparing women with infants who have complex needs to go home?
What would it look like when women with infants who have complex needs go home from hospital successfully and safely?
Who are some of the other people who work with you to plan discharge.

Ending Questions:

If there is something you would like to happen differently for women going home with babies with complex needs what would it be?
What would you like to see in place that would make this job work?
Is there anything else you think I should know to understand what it is like for you in your role?
Is there anything else you think I should know about how maternity/neonatal services and child health services work together?
Some people call this work collaboration, what do you call it?
Is there anything you would like to ask me?

Appendix B3 Interview Guide – Women Participants

Opening Questions:

Can you tell me about what it has been like coming home from hospital?
Can you tell me about the information you received?
What has your experience been with hospital services?
What has your experience been with child health services?

Intermediate Questions:

Tell me about what happened when you were getting ready to go home from hospital?
What specific things were important for you and your family when going between hospital and home?
What do you know about what was arranged when you left hospital?
What are the most important aspects to you about getting back home?
What was important or not important about meeting up with child health services when you left hospital?
Have you had any further contact with the hospital after you have come home?
What/who has been the most assistance to you in returning home with your new baby?

Ending Questions:

Is there something you would have liked to have happened differently when you left hospital?
Is there something you would have liked to have happened differently when you met up with child health?
Are you planning further visits with child health?
Is there anything else you think I should know to understand your experience of the return to home better?
Is there anything you would like to ask me?

Appendix C Policy Documents

Australian College of Children and Young People's Nurses, 2009. *Position Statement: Minimum Standard for Nurses Caring for Children and Young People*.

Australian College of Midwives, 2013. *National Midwifery Guidelines for Consultation and Referral, 3rd Edition*.

Australian Health Ministers' Advisory Council, 2010. *National Maternity Services Capability Framework.*

Australian Health Ministers' Advisory Council, 2011. *National Framework for Child and Family Health.*

Australian Health Ministers' Conference, 2009. *The Australian National Breastfeeding Strategy 2010-2015.*

Australian Health Ministers' Conference, 2011. *National Maternity Services Plan 2010.*

Australian Research Alliance for Children and Youth, 2010. *Working Together to Prevent Child Abuse and Neglect – A Common Approach for Identifying and Responding Early to Indicators of Need.*

Children's Health Queensland Hospital and Health Service, 2013. *Children's Health Queensland Strategic Plan 2013-2017*

Council of Australian Government, 2009. *Investing in the Early Years*.

Council of Australian Governments, 2009. *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020.*

National Health and Medical Research Council, 2010. *National Guidance on Collaborative Maternity Care.*

Council of Australian Governments, 2011. *National Health Reform Agreement*.

Department of Health and Ageing, 2009. *Improving Maternity Services in Australia: The Report of the Maternity Services Review.*

Department of Health and Ageing, 2011. *National Health Reform Progress*.

Metro North Hospital and Health Service, 2013. *Strategic Plan 2013-17*.

National Health and Hospitals Reform Commission, 2009. *A Healthier Future for All Australians.*

National Preventive Task Force, 2009. *Australia: The Healthiest Country by 2020.*Department of Health and Ageing. 2010. *Building a 21st Century Primary Health Care System.*

New South Wales Health, 2011. *Child and Family Health Nursing: Professional Practice Framework 2011-2016.*

Nursing and Midwifery Board of Australia, 2006. *Code of Professional Conduct for Midwives in Australia.*

Nursing and Midwifery Board of Australia, 2006. *Code of Professional Conduct for Nurses in Australia.*

Nursing and Midwifery Board of Australia, 2008. *National Competency Standards for the Midwife.*

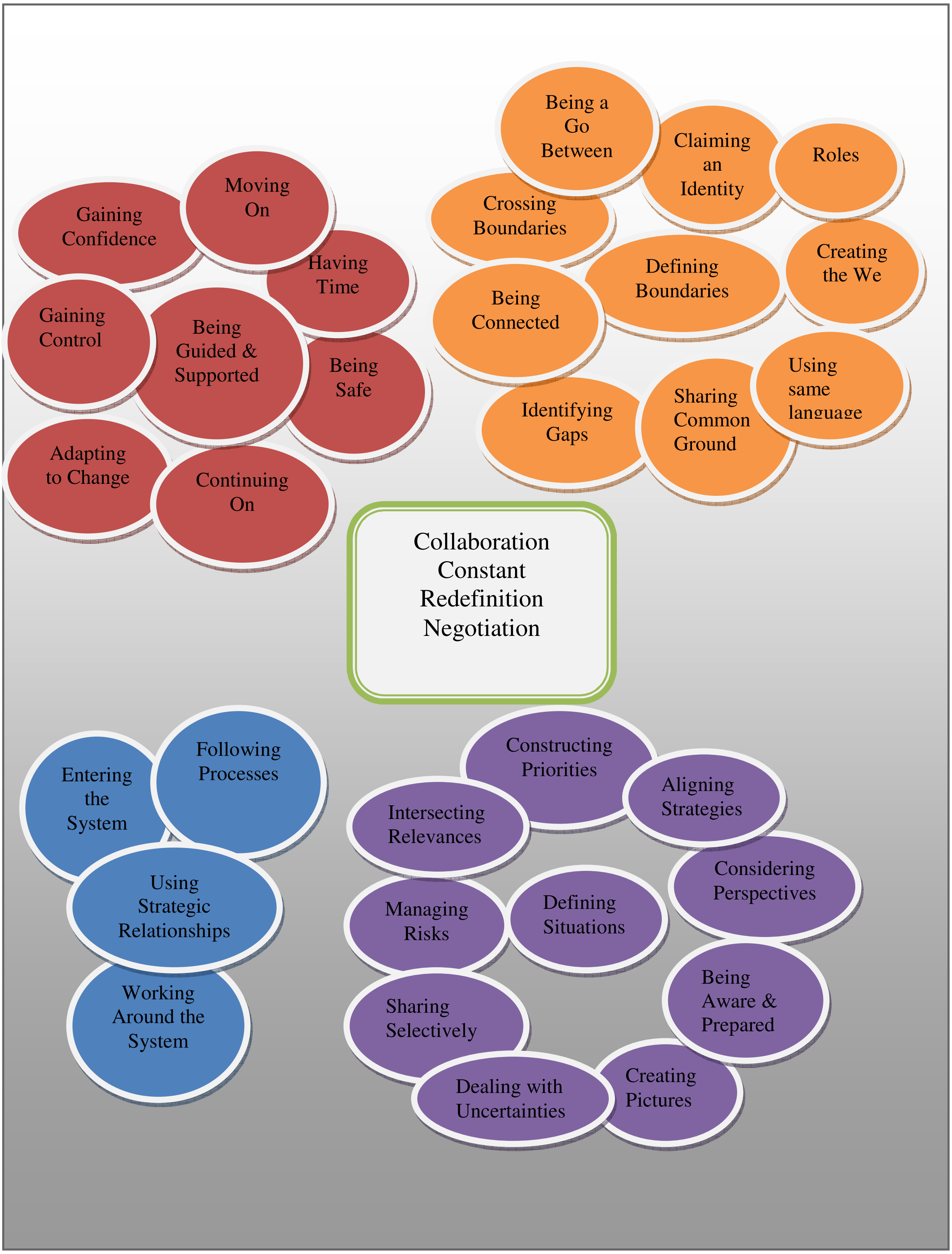
Nursing and Midwifery Board of Australia, 2008. *National Competency Standards for the Registered Nurse.*

Queensland Health, 2013. *Blueprint for Better Healthcare in Queensland.*

The Allen Consulting Group (on behalf of Australian Research Alliance for Children and Youth), 2008. *Inverting the Pyramid: Enhancing Systems for Protecting Children.*

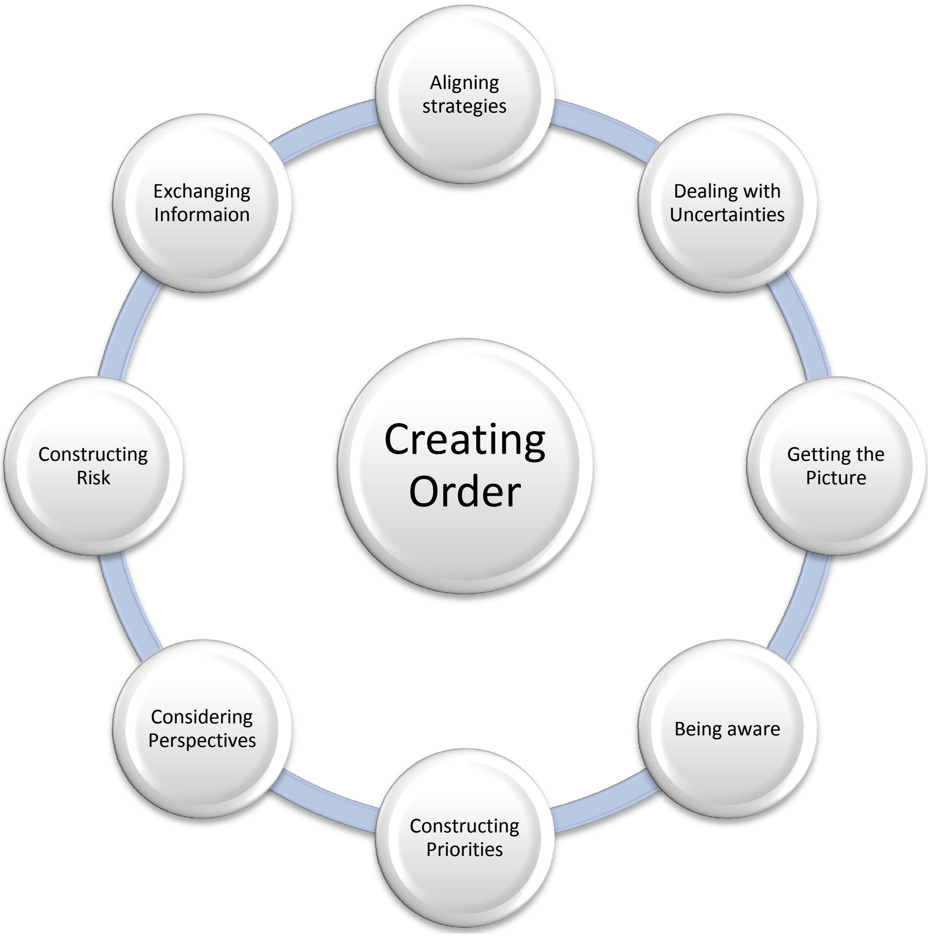
The Allen Consulting Group, 2010. *A Common Approach to Identifying and Responding Early to Indicators of Need: Guidance Manual for Universal Service Providers.*

Appendix D Early Coding Groups



April 2012 Version Four Coding Groups

Appendix E Category Map: Creating a Knowledge Order



Appendix F An Early Memo

Ordering Information

Defining situations and exchanging information comes with the assumption that information is power and knowing all that is possible about a situation means being justified to pursue certain interests for example advocacy for the child or women by covertly managing risks. However the contradiction is that information is selectively shared, there is a lot of uncertainty here, priorities and perspectives vary and situations appear to change all the time.

However, there is an assumption that the most credible account in this situation is that made by the professionals and this may in some way be given greater credibility because certain professional knowledge is used to interpret information and render it more important than the view of another.

The ultimate contradiction is that this does not fit with families as experts and partners in care. Becker suggests that credibility and the right to be heard are differentially distributed through the ranks of systems like this. To give credibility to women and parents as experts as sometimes suggested here means on another hand a disrespect for the entire established order and that (using Becker's thoughts) health professionals do this as 'responsible officials' who have been entrusted with care and the operation of the health system but also entrusted with the care of the young and vulnerable while also managing their own professional positions. Health professionals perceive themselves in positions of authority and with this comes being legitimately able to 'do something' when things are not what they should be and indicates who will be held to account if they fail to 'do something' or do something inadequately. Both of these latter comments are about professions.

5th May 2012