The value and challenges of collegiality in practice

Burr SA, Collett T & Leung YL

The ability to work optimally with colleagues is considered to be a valuable determinant of success, but collegiality is a challenge to assess. Could you be more collegial, and what might be the benefits and drawbacks for clinical practice? How could you be more collegial and foster more collegiality amongst those you work with?

What is collegiality and what does it mean to be collegial?

Collegiality can be defined as the relationship between individuals working towards a common purpose within an organisation. The concept has its origins in the roman practice of sharing responsibility equally between government officials of the same rank in order to prevent a single individual from gaining too much power. In contrast, managerialism does not provide opportunities for exploring democratic consensus because it promotes being responsive and obedient to implementing the wishes of authority (Dearlove, 1997, King, 2004). Collegiality emphasises trust, independent thinking and sharing between co-workers. This encourages both autonomy and mutual respect and can impact on organisational efficacy (Donohoo, 2017). In modern day practice, the focus is less on sharing responsibility between officials of the same rank and more on ensuring that all employees within an organisation are treated with equal respect as individual people (Lorenzen, 2006).

Collegiality is often seen as unproblematic (something 'we just do'). An alternative perspective, is that collegiality is a form of action or work that like other personal actions can have a significant effect on the culture of an organisation. Seen in this way collegiality carries considerable responsibility. Collegiality is different from congeniality (enjoying each other's company) and distinctive from, but a feature of, collaboration or teamwork (working with others). Being collegial involves building a rapport and learning about and from each other (Hoerr, 2005). It pivots on the quality of relationships with all other categories of staff (Rogers & Holloway, 1993). These relationships require honest self-disclosure, to permit the development of trust that each will act in the best interests of another, and know the limits within which they can independently manage tasks and risks on behalf of the other member of staff.

What are the benefits of collegiality to your clinical practice?

A consideration of collegiality requires an understanding of the social context within which it takes place. Most professions are 'self-regulated' (Freidson, 1970), both formally and informally. Informal self-regulation takes place at the coalface, on a daily basis in the workplace amongst employees, and is subject to cultural norms and unwritten rules. When the process of informal self-regulation is ignored there is a danger that everyday decisions and actions that are detrimental to staff morale and patient care may develop and persist. Importantly, when groups do not articulate but 'assume' a shared purpose, detrimental habits of action can occur (Norros and Klemola, 2010).

In the current climate of litigation it is vital that colleagues hold each other accountable for the quality of patient care. As the recent literature has consistently pointed out, it is risky to act in isolation (Reckless et al, 2013). Importantly, collegial interactions increase the opportunity for dialogue and reflection, developing a culture of trust in which staff actively learn with, learn from, and teach their colleagues (Hoerr, 2005). Thus everyone involved is informed by the combined knowledge and experience of the collective, and so grows in ability and practices more safely.

What are the benefits of collegiality to Healthcare?

A more collegial, unified relationship between staff has the value of enabling staff to combine their power to improve patient care (Gianakos, 1997). A collegial work environment has a sense of belonging, open communication, cooperation and support amongst staff, effectively managed conflict, a high work satisfaction, and consequently a high staff retention (Duddle & Boughton, 2009). A combined approach to the challenges of work is good for individual growth, service improvement, and can also facilitate cross-cover through increased institutional memory. Clearly a collegial culture has the advantage of empowering individuals to get the optimum benefit from their potential to contribute. Furthermore, collegial leaders make it easier for staff to raise contentious issues (Hoerr, 2005). A collegial work environment also makes it easier to identify and manage difficult staff such as those who bully, harass, think their needs are the most important, avoid work, or have other questionable individual approaches to work (Waggoner, 2005). When healthcare workforce morale is low, then the dedication, extraordinary efforts, and love of the professional vocation exhibited by staff (Sharp, 2016) can bolster service resilience if there is also a pre-existing collegial culture.

How can you improve your collegiality?

The main challenge for an individual to develop a collegial approach is the willingness to be open in order to develop the trust of others (Jones, 1997). This is because collegiality requires an awareness not only of each other's strengths to be able to capitalize on them, but also of each other's weaknesses to be able to shield them. Thus, opportunities to communicate (Lister, 2003) and develop professional intimacy (Rogers & Holloway, 1993) are particularly important. Professional intimacy is nurtured by: mutual interests; the celebration of accomplishments; collaborative projects; interactions at external engagements; and, the revelation of feelings and vulnerabilities regarding work (Rogers & Holloway, 1993). In medical practice this involves, where appropriate, discussing patient needs with other staff; discussing service needs with staff; observing staff in practice; being observed by staff in practice; teaching staff; being taught by staff; and, learning together with staff (Hoerr, 2005). These activities are important because the common goal of patient wellbeing is more important than the success of an individual member of staff. Differences of opinion can lead to feelings of conflict, and it can be helpful to undertake training in conflict resolution (Lorenzen, 2006). By learning how to separate emotions from conflict, it is possible to mediate compromises and even accept decisions you do not agree with without taking them personally. Thus, it is important to model positive behaviours: keep emotions detached from decision making; focus on the task; ensure everyone feels ownership; not let negative comments that undermine individual staff members pass unchallenged; use good humour to relieve tension and keep things in perspective; and, acknowledge and celebrate success.

How can collegiality be fostered in the workplace?

The main challenge for any organisation is to have a clear vision that staff can both relate to and 'be empowered to achieve'. Transcending personality, a strong culture offers a clear sense of expectation to everyone about what is important (Hoerr, 2005). If staff hold the belief that they are unappreciated then their performance may suffer and this may have a negative impact on patient welfare. For those with responsibility for leading, one quality matters most of all: the ability to build relationships with, and inspire, staff at all levels. Nohria et al (2003) argue that leaders who present themselves as fellow employees (rather than masters) can encourage positive attitudes that have a beneficial impact on performance. A collegial culture can evolve as staff define and develop their own community with support from management. Deal and Peterson (2016) suggest that many eminent organisations have evolved a shared system of informal systems and traditions that infuse work; for example, with meaning, passion, and purpose. In contrast, attempts to contrive collegiality administratively by imposing interactions amongst staff, where they meet and work to implement the strategies developed by others, facilitates more managerial control without enhancing staff and service development (Hargreaves, 1990).

The degree to which someone in a particular role is expected by co-workers and the public of being able to 'play well with others' (Jones, 1997) depends on how much of an individual's role is self-directed as opposed to requiring interaction with others (Lorenzen, 2006). Collegiality can be encouraged by decentralising tasks, rotating roles and working on cooperative projects (Frank et al., 1991). Meetings should be events that provide an effective safeguard against concealment of errors, and an opportunity for all staff to learn. Sharing successes makes it easier to share failures, to benefit everyone, with good humour and support, bringing staff closer together (Hoerr, 2005). It is also advisable to involve staff at all levels in selection and recruitment to maximise 'team fit' and send a clear message about how the opinions of staff are valued. Mentoring prior to entering practice increases collegiality (Scott, 2005). Another method that could encourage collegiality is supervisory intervention when someone is acting in a non-collegial manner. Often people do not realise that their actions are disruptive (Lorenzen, 2006). Multisource feedback are useful for assessing collegiality (Violato et al., 2003). Training in giving and responding to feedback *per se* is valuable. To bring all this together, setting collegiality as a formal goal evaluated in appraisals, with appropriate rewards and celebrations of success, ensures staff are appropriately motivated (Hoerr, 2005).

What are the potential drawbacks of collegiality?

Excessive focus on working closer together could hinder individual innovation. Unique perspectives that are unsupported by the values of the existing majority may be undervalued. An established opinion may be difficult to change. This can be offset by establishing strategic principles, such as a requirement that innovation is to be encouraged, but that change must be evidence based. In the transition to a new workplace the process of integration depends on developing collegiality. Consider what informal advice you would give to new staff. There may be delays in the integration of newcomers because of 'ingroupism' and expectations of power-relationships (Congton & French, 1995). Collegiality depends on spending time to get to know and relate to others. Thus a collegial

approach to decision making may be slow (but having the advantage of taking into account practical considerations from those with most experience), while also being less responsive to authority. Furthermore, collegiality requires the sharing of experiences and personal circumstances, and knowledge about the degree of shared values with different individuals. Therefore collegiality has the additional disadvantages of being susceptible to favouritism and bias (Leung et al., 2011), and being similarly predisposed to allegations of preferential treatment of colleagues over non-colleagues. Thus emphasis on collegiality can create tension when there are responsibilities to patients, leading to personal professional dilemmas that can be difficult to resolve (Campbell, 2006).

Conclusions

Collegiality works when the goal of work (e.g. patient wellbeing) is recognised as more important than the personal ambitions of staff. The main requirement for a collegial approach is to treat staff at all levels with respect as equal individuals. This then helps to facilitate the honest sharing of weaknesses, as well as strengths, to develop the trust needed so that staff know the limits within which they can act for each other. Individuals benefit by learning from each other, and sharing responsibility for decisions. The workplace benefits by staff being empowered to contribute their full potential, maximising the effectiveness of sharing knowledge and experience, and thereby improving patient safety, work satisfaction and service resilience. On the downside, collegiality can be slow to respond to change, and can be susceptible to personal biases and preferential treatment, which can lead to professional dilemmas. Collegiality can be improved by opportunities to communicate and develop professional intimacy, and an understanding of biases, mediation and conflict resolution. It is important to realise that collegiality can't be imposed, but that staff at all levels can be motivated by appropriate rewards.

References

Campbell E (2006) Ethical Implications of Collegial Loyalty as One View of Teacher Professionalism. *Teachers and Teaching* **2**(2): 191-208 (http://dx.doi.org/10.1080/1354060960020203)

Congdon G, French P (1995) Collegiality, adaptation and nursing faculty. *Journal of Advanced Nursing* **21**(4): 748-58 (doi: 10.1046/j.1365-2648.1995.21040748.x)

Deal TE, Peterson KD (2016) *Shaping School Culture.* 3rd ed. Jossey-Bass: Wiley

Dearlove J (1997) The academic labour process: from collegiality and professionalism to managerialism and proletarianisation. *Higher Education Review* **30**(1): 56-75

Donohoo, J (2017) *Collective Efficacy: How Educators' Beliefs Impact Student Learning*. Sage

Duddle M, Boughton M (2009) Development and psychometric testing of the Nursing Workplace Relational Environment Scale (NWRES). *Journal of Clinical Nursing* **18**(6): 902-9 (doi: 10.1111/j.1365-2702.2008.02368.x)

Frank P, Levene L, Piehl K (1991) Reference collegiality: One library's experience. *The Reference Librarian* **15**(33): 35-50 (http://dx.doi.org/10.1300/J120v15n33_04)

Freidson E (1970) *Professional Dominance: The Social Structure of Medical Care*. Aldine de Gruyter

Gianakos D (1997) Physicians, nurses, and collegiality. *Nursing Outlook* **45**(2): 57-8 (http://dx.doi.org/10.1016/S0029-6554(97)90079-8)

Hargreaves A (1990) Paths of professional development: Contrived collegiality, collaborative culture, and the case of peer coaching. *Teaching and Teacher Education* **6**(3): 227-41 (http://dx.doi.org/10.1016/0742-051X(90)90015-W)

Hoerr JR (2005) *Art of School Leadership*. Alexandria, VA: Association for Supervision and Curriculum Development

Jones DA (1997) Plays well with others; or, the importance of collegiality in a reference unit. *The Reference Librarian* **28**(59): 163-75 (http://dx.doi.org/10.1300/J120v28n59_18)

King V (2004) Cooperative reference desk scheduling and its effects on professional collegiality. *The Reference Librarian* **40**(83-84): 97-118 (http://dx.doi.org/10.1300/J120v40n83_09)

Leung YL, Adesara S, Burr SA (2011) Learning to make better clinical decisions. *BJHM* **72**(11): 642-5 (doi: 10.12968/hmed.2011.72.11.642)

Lister L (2003) Reference services in the context of library culture and collegiality: tools for keeping librarians on the same pages. *The Reference Librarian* **40**(83-84): 33-9 (http://dx.doi.org/10.1300/J120v40n83_04)

Lorenzen M (2006) Collegiality and the Academic Library. *The Electronic Journal of Academic and Special Librarianship* **7**(2): accessed 15/03/17

Nohria N, Joyce W, Robinson B (2003) What really works. *Harvard Business Review* **81**(7): 42-52

Norros L, Klemola U (1999) Methodological considerations in analysing anaesthetists' habits of action. *Ergonomics* **42**(11): 1521-1530 doi.org/10.1080/001401399184866

Reckless I, Reynolds D, Newman S, Raine J, Williams K, Bonser J (2013) Avoiding Errors in Adult Medicine. Oxford: Wiley Blackwell

Rogers JC, Holloway RL (1993) Professional intimacy: Somewhere between collegiality and personal intimacy? *Family Systems Medicine* **11**(3): 263-270 (http://dx.doi.org/10.1037/h0089049)

Scott ES (2005) Peer-to-Peer Mentoring: Teaching Collegiality. *Nurse Educator* **30**(2): 52-6

Sharp T (2017) Has NHS workforce morale hit rock bottom? *BMJ* **356**: 361

Violato C, Lockyer J, Fidler H (2003) Multisource feedback: a method of assessing surgical practice. *BMJ* **326**(7388): 546-8 (doi: 10.1136/bmj.326.7388.546)

Waggoner J (2005) When colleagues are brats. *Academic Leader* **21**(8): 3-5