“It’s Not Just About Getting Along”: Exploring Learning Through the Discourse and Practice of Interprofessional Collaboration

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Abstract

Purpose
Interprofessional collaboration (IPC) is a necessary competency for all professionals. However, IPC can be fraught with politics leading to variable uptake and execution. The authors set out to understand how trainees come to appreciate the value of the “team” in their learning and to describe the type of learning related to IPC afforded to trainees in a highly collaborative complex care context.

Method
The authors conducted 72 hours of observations of pediatric rheumatology settings at a large pediatric hospital across 18 months. They interviewed 10 health professionals and analyzed an archive of texts to ascertain how the field of pediatric rheumatology conceptualizes the role of IPC. They used the concept of governmentality and critical discourse analysis to describe how values of collaboration enabled learning and theories of expertise to understand how learning was enacted and perceived.

Results
Collaboration was perceived to be a product of providing good rheumatological care, which in this case, aligned well with hospital model of IPC. This alignment afforded trainees learning opportunities beyond preparing them to get along with other health professionals. IPC, when role modeled during problem solving, created the conditions for learning “why” collaboration is important for clinical expertise.

Conclusions
By critically examining the relationship between discourse, practice, and learning, the authors have described how practices that underpin collaboration as a clinical competency are distinct from collaboration as cultural work contributing to civility within teams and across the organization.

Over the past 20 years, a culture of interprofessional collaboration (IPC) has come to permeate most North American clinical contexts. Support for an interprofessional approach is often associated with ideas that it is the “best” or “better” way to provide health care. Moreover, there is a robust literature drawing out the benefits of IPC including enhanced communication between experts and patients, decreased duplication of services, more comprehensive care for patients, and more timely access to health services.

IPC has thus emerged as a dominant discourse in health care contexts and has generated a change in the way that health care organizations invest resources and effort to organize health care delivery and health professions education. In education, this shift has supported the ascent of collaboration from a “soft skill” to a necessary competency for all health care professionals. Educators now strive to deliver training that will prepare trainees to practice effectively in teams. The most common starting point is to assume collaboration is role modeled in environments where it is organizationally supported and therefore a competency acquired while doing health-related tasks. Interprofessional education, when present in curricula, is focused on improving communication skills and providing exposure to what other professionals do to presocialize future generations of health professionals to a team orientation that includes understanding of the roles, responsibilities, and professional boundaries of other team members and a respect for the patient voice.

However, studies exploring hidden curriculum effects suggest that IPC can be fraught with politics particularly when it comes to deciding what knowledge counts in the context of problem solving. These issues are attributed to professional entrenchment and historically enduring hierarchical structures that interfere with the proper implementation of IPC. Our previous work fits in this line of research and suggests that shifts in organizational mandates are not always accompanied or aligned with shifts in how health care providers approach their clinical work, resulting in poor IPC. Furthermore, there is evidence that different professions invest in IPC strategically for different reasons such as improving one’s position on a team or within an organization, achieving a stronger voice in patient care, developing efficiencies for a particular task, sharing responsibility, developing new competencies, etc. This line of research exposes a sociocultural variability in the uptake of IPC that theoretically suggests we should investigate more specifically how health care professionals come to appreciate collaboration as an important
mechanism in the development and application of clinical expertise. Such an approach can help separate activities and practices that underpin collaboration as a clinical competency from collaboration as cultural work contributing to civility within teams and across the organization. This separation is critical and must be explored as we continue to move to a competency-based model of education that demands that collaboration be assessed as a core component of expertise in different clinical contexts.

To address this gap, we studied how subspecialty trainees are acculturated into a mentality of IPC at the Hospital for Sick Children (SickKids) pediatric rheumatology division. We were interested in understanding how trainees learn to perform and/or to perceive others performing a successful IPC skill, behavior, attitude, and/or practice. Accordingly, we set out to: (1) understand how trainees come to appreciate the value of the “team” in their learning and (2) describe the type of learning related to IPC afforded to trainees in a highly collaborative complex care context.

Method
Research design
We drew on the Foucauldian concept of governmentality20–22 which premises a coconstituting relationship between discourses (institutionalized systems of ideas, values, and practices) and subjectivity (the roles and professional identities people feel supported and authorized to occupy in relation to specific discourses). Governmentality refers to the “conduct of conduct”21; namely, the culture of self-regulation that develops in relation to specific discourses. It has expansive meaning and includes the exercise of power through formal instruments of governing as well as the sociocultural and moral premises that individuals draw on to justify and authorize their day-to-day behaviors and practices. In relation to our study, we used the construct of governmentality to identify how members of the Division of Rheumatology at SickKids rationalized the importance of working in interprofessional teams in relation to their clinical work and how collaboration thus factored in their perception of professional self. We combined the construct of governmentality with the framework of adaptive expertise23,24 for understanding how procedural (knowing what to do) and conceptual knowledge (knowing why they doing it) related to IPC was developed in the context of rheumatological training.

Methodologically, we employed ethnographic methods of observation and interviewing to develop a rich description of the “culture of collaboration” in relation to rheumatological practice, to catalogue examples of how trainees use the structure of a team to enhance their learning and to describe how IPC discourses are specifically experienced by faculty and trainees as they consider their roles in the acquisition of expertise. We thus focused our analytical work on how participants constituted themselves as “good rheumatologists” in relation to the prevailing discourses of IPC. This strategy was developed following a comprehensive literature review and considerable pilot work (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B3). The pilot work also informed our sampling strategy, the development of the interview protocol, and the observational field note protocol. Importantly, acuity and complexity emerged in our pilot work as organizational principles in the practice of IPC, including justifications for abandoning etiquettes of interprofessional civility and other interpersonal aspects of what is promoted discursively as “good” team care (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B3). We thus set out to explore more explicitly the relationship between IPC discourses, perceived complexity, and acuity of clinical work and learning afforded by team practice. The Division of Rheumatology at SickKids was determined to be an ideal context for this research for 3 interrelated reasons: (1) conceptually, the nature of rheumatoid diseases makes them inherently complex with a high risk of acuity, involving multiple systems in the body; (2) procedurally, team practice is the profession’s preferred approach to the evaluation, diagnosis, and treatment of patients with rheumatological diseases; and (3) culturally, educators and trainees consider the rheumatology division at SickKids to be one of the most collaborative units within the hospital. We thus reasoned that this clinical context would provide opportunity to explore the relationship between collaboration as core to clinical expertise and collaboration as a cultural imperative.

Setting and participants
The Rheumatology Division at SickKids is one of the largest clinical training sites in North America and the core-training site for the Advanced Clinical Practitioner role in Arthritic Care (ACPAC), a health professional role that has evolved to further reinforce the interprofessional practice of rheumatology.25,26 A comprehensive range of inpatient and outpatient services are offered for children with pediatric rheumatic diseases, including subspecialty clinics for lupus, neonatal lupus, juvenile dermatomyositis, morphea, systemic juvenile spondyloarthritis, CNS vasculitis, systemic vasculitis, and autoinflammatory syndromes. Subspecialty residents, referred to as fellows, are thus afforded a rich clinical experience and the opportunity to learn to assess and manage the full spectrum of pediatric rheumatic diseases.

Data collection
The primary sample for our study were fellows, training in rheumatology at SickKids over the course of 2 consecutive academic years. We do not report the actual dates of training to protect the identity of participants. A secondary sample for our study were all staff delivering care at the division. This study was approved by the Hospital for Sick Children Research Ethics Board (Study # 1000045583). We received ethical approval from the SickKids Ethics Board for both our pilot work and our current study.

Data collection took place in 3 phases over the course of 18 months and was composed of a combination of public domain texts, observations, informal interviews, and formal semistructured interviews.

Texts. An archive of public domain texts related to North American pediatric rheumatology practice in general and SickKids specifically was compiled to document the profession’s and the hospital’s rationale for delivering care in teams. Included in the archive were expert literature, reports, and websites.
published in the past decade that spoke to the role of collaboration in the delivery of care specific to pediatric rheumatology and SickKids.

**Observations.** We conducted 24 separate observations approximately 3 hours each for a total of 72 hours of observations in inpatient and outpatient settings at SickKids across 18 months. Six fellows and 28 staff consented to being observed in their daily work. The bulk of the observations were conducted by O.F. with the exception of the first few which were conducted together with M.A.M. for the purpose of establishing the sites of observation and refining the observational approach. Observations were pursued from the perspective of trainees (N = 6) to provide a rich description of the values, practices, and processes that are associated with collaboration and interprofessional practice as they emerged in training. We used the taxonomy of different learning constructs generated during our pilot work (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B3) to focus the observations to activities and practices that pertained to learning afforded by IPC. To minimize observational effects, we varied the length of observation sessions and spread them over many months, took notes of moments when the researcher suspected that behaviors were being altered due to their presence, and used the interview data to compare and confirm findings from observations.

**Informal interviews.** Informal interviews were conducted by O.F. and captured within observational field notes. These were opportunities to clarify observations, or to ask trainees what they learned from observed interactions so that we could more accurately connect social interactions with the cognitive process of learning.

**Formal interviews.** Experiences, attitudes, and perceptions regarding IPC and learning were explored through 10 one-hour, semistructured interviews with 2 fellows, 3 rheumatologists, 2 physical therapists, 1 nurse, 1 adolescent physician, and 1 psychiatrist recruited purposively during the observation phase conducted by O.F. or M.A.M. The interview guide was organized around conceptual, procedural, and cultural dimensions of collaboration and intended to elicit specific examples of learning afforded by practicing in teams in this division (see Supplemental Digital Appendix 2 at http://links.lww.com/ACADMED/B3). Participants were asked to describe their personal philosophy regarding team practice, to recount experiences of learning from practicing in a team, to describe team dynamics they find helpful or unhelpful in the context of patient care, etc. At the time of recruitment, the unit was experiencing study fatigue as several large-scale clinical studies were also underway and competing for staff and learner attention and participation. Our commitment to work with the unit and not interfere with day-to-day clinical work led to our decision not to pursue more participant consents. Instead, for the dissemination phase, we compared our study findings with the results of our pilot study (for which we also observed and interviewed staff in the same hospital in different contexts). This allowed us to distinguish elements of learning that transcended clinical context and to zero in on aspects that were specific to rheumatology.

**Data analysis**

Texts were read by M.A.M. to identify discourses related to collaboration and their relationship to the practice of rheumatology. We captured evidence of the collaborative mentality of the unit and the rationales for pursuing team care articulated at the level of profession and the organization. The results from this analysis were used to contextualize the results from the observation and interview phases of the study. Data analysis of observations and interviews occurred iteratively and commenced after the first scheduled observation and interview, respectively. Field notes were generated by O.F. after each observation. Interviews were recorded, anonymized, and transcribed professionally. Analysis of transcripts and field notes was conducted by M.A.M., M.M., and O.F. and was informed by the concept of governmentality20–22 and the framework of adaptive expertise.21,24 Specifically, we identified how participants strategically deployed IPC discourse in the care of patients and their rationales for working collaboratively. We also documented instances of learning and problem solving enabled by IPC and noted how participants made sense of the role of team in their education. Analytical findings were refined through ongoing discussion with S.T. and R.S. To protect the anonymity of participants, S.T. and R.S. only reviewed findings that contained anonymized excerpts from interview transcripts and field notes.

**Results**

The results are presented as an integrated analysis describing the relationship between IPC discourses, learning, and team practice. To protect the anonymity of participants, we only report their role/subject position.

**Collaboration enhances complex care**

Rheumatology as a field promotes IPC discourses that explicitly reproduce the statement that patients who suffer from musculoskeletal conditions are better served by health care providers who actively integrate expertise and treatments from multiple health care disciplines. Table 1 includes examples from our archive that show the alignment between rheumatology and hospital-wide discursive rationales for engaging in IPC.

Mirroring our pilot data, more nuanced assessments were provided by others who saw collaborative practice as occurring on a case-by-case basis depending on patient needs:

> M: Does that frequently occur in rheumatology practice, the coming together of the group, or this kind of IPC?

> R: I would definitely say so. Everybody has got their own role that they’re playing, but there’s definitely communication between the teams. It’s on a case-by-case basis, depending on what each patient needs, but I’d say everyone is very good at communicating when they need assistance from other members of the team [and] very good about providing help and services when they’re needed. (Fellow)

Learning how to problem solve with other health care professionals was perceived as distinct from developing communication skills for getting along socially with other people. In our example, the participant has embodied the IPC discourse but does not perceive collaboration to be a teleological outcome of interprofessional interactions or a demonstration of organizationally expected and acceptable behaviors. It is instead described as a tool for accessing knowledge and expertise located in the
Collaboration is perceived to be a product of providing good rheumatological care, which, in this case, aligns well with hospital-preferred model of IPC. Even so, contextual and situation factors reinforce the appreciation that IPC is not always required.

The team is constructed around the patient both physically and ideationally. Collaboration is perceived to be a product of providing good rheumatological care, which, in this case, aligns well with hospital-preferred model of IPC. Even so, contextual and situation factors reinforce the appreciation that IPC is not always required.

Learning opportunities in a highly collaborative complex care context

IPC discourses embodied by members of this unit created a number of unique learning opportunities for trainees. Fellows learned when to engage in IPC through everyday practices that were primarily observed in an outpatient clinic. Two adjacent rooms, connected by a door, were the primary spaces in which the rheumatology team discussed patients, accessed reports/images on dedicated computers, and engaged in friendly conversation with others in the interprofessional team. In the midst of this congeniality, a division of labor that served to delineate certain roles and responsibilities to various professions was also discernible. “Intakes” were done by nurses who filled out the intake note and placed it on a shelf in one of the 2 rooms, to be picked up by a fellow or a staff physician for follow-up.

At times, these exchanges were accompanied by a brief update by the nurse on the patients’ condition.

Dr. is back at the bulletin board looking at the names of the patients. Nurse walks in a short while later. “[Name of patient]? I don’t recognize her. Let’s have a look,” says Dr. to nurse. “I precliniced her,” says nurse. Dr. and nurse then check the patient’s chart on a computer. “We did see her in February,” says Dr. “Did I not send the list around? Did I not?” asks nurse. Nurse’s questions appears to underscore the role of the nurses in creating patient rosters for the week and then informing the staff (and possibly also the fellows) of the patients to be seen. (Field note)

Fellows learned to appreciate the role of IPC from staff, peers, patients, nurses, and other allied health professionals. In most instances, this occurred by observing staff who embodied collaboration as part of problem solving.

Fellow 1 calls from [ward] and speaks with a resident who informs the others in the room that there is an 11-year-old child with fever since mid-December, thigh pain, [unclear] lesions, high white counts and keratin of 2,000. Dr. recommends admitting the patient while

broader sociocultural context as required by the specific clinical task.

The tendency to collaborate to a greater degree around in-patients was attributed to both patient acuity and the proximity to interprofessional expertise when patients were admitted to the ward:

[i]?patients generally should have higher acuity and more significant issues, at least from a medical perspective, so they get not only prioritized because they’re physically here, but then everybody has access to them in that they’re here all the time. So, social work can go at 9:00 AM and what works with their schedule versus one clinic appointment is scheduled around the physician’s schedule, and then it just depends whether other people can make it to that one appointment. (Fellow)
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nurse pulls the child’s bloodwork on a computer, and nurse, Dr., and fellow 2 check the numbers. Someone [unsure who] mentions “active MAS.” (Field note)

Direct teaching of fellows by allied health professionals that reinforced the importance of expertise from other fields was also observed:

The Dr. takes out some pads that had been placed on the patient's body. The fellow observes from the side of the bed. The PT wipes off/swabs the injection site with a liquid. She then proceeds to do an exam of the patient’s arm and the extent to which it can be moved. She raises the patient’s arm slowly and says “If I feel any resistance, I’ll stop.” The PT then asks the fellow to hold up the patient’s hand while she takes a measurement. The PT then takes over once again and rotates the arm in a different direction. The patient wiggles his toes. “He didn’t like that,” says the Dr. having seen the toes move. The PT teaches the fellow: “So if you feel right here, see the joint [unclear] open?” (Field note)

While limits to IPC were envisaged, they did not challenge the primacy of the role of IPC: “There are many shades of gray, and I often don’t have to make a decision that day. There are times when I have to … in which case … it’s my call.” (MD)

The perceived importance of IPC in clinical problem solving is noticeable in the way the above comment is immediately mitigated by references to acuity rarely requiring immediate uniprofessional response and in the evocation of time for team reflection: “ … but it usually isn’t of such grave import … that I couldn’t also say there is time for us to step back, and rethink for a little while before a final decision is made. I know that’s kind of a wishy-washy answer.” (MD interview continued)

The respect for the expertise and validation of nurses and other health care practitioners was constantly modeled by the attending staff in relation to clinical problem solving. We observed fellows and attending physicians rely on information from the intake assessment—and allowing this information to set the tone for patient encounters. By using the information provided by the nurse in their encounter with the patient and expecting the fellows to do the same, the physician legitimized the role of other health professionals and made the patient feel cared for by an entire team rather than experiencing care delivered in multiple encounters as disjointed and/or obtrusive. Nevertheless, the commitment to IPC was at times constrained by perceptions of medicine’s dominance internalized by other health professionals and sometimes reinforced by patients:

The nurse adds that the child is unable to play soccer. “The child likes to do things, but the dad holds him back,” says the PT. “But he needs to hear from a doctor—there’s a hierarchy there,” she adds, verbalizing here the fact that the family has internalized the notion of medicine’s dominance. (Field note)

They ask us questions, and we tell them what we’re observing or what our findings are, and collaboratively, we’ll make our suggestions and they’ll act on them or not. (Nurse)

These examples reinforced the need for physicians to explicitly socialize fellows to the importance of collaborative decision making in achieving the best outcome for the patient.

What is perceived to be “learning”?

As we expected, IPC discourse permeated the rheumatology division: “I think collaboration is so valuable and in the best interests of the patient” (Fellow)

The disciplining effects of the discourse were visible but not resented as they came with several perceived intrinsic and extrinsic rewards. As noted previously, the clinical benefits of collaboration were modeled and validated daily by the physicians:

I have learned not to have an ego … by definitely watching mentors and staff physicians. They would just be very humble about their decision making. Clearly, they know what is going on, and they know the diagnosis and the treatment that they want to do, but still verifying it and getting the broader scope, even asking the nurses. What do you think? How have you seen this? How can we get the patient to take their medications? Do you have any suggestions? And … getting information from the whole team, in general, to make the best plan for the patient. (Fellow)

This culture of IPC set the stage for learning that was not always predicted or planned for in the formal curriculum. Fellows came to perceive useful and important professional competencies in all team members, and thus learning from other members of the team became foundational to the development of their own expertise:

When I have the OT or PT come in, they’ll identify something in the physical exam, like a way of looking at a joint, or certain movements that they would do or test that I wouldn’t necessarily do so it definitely adds to my overall knowledge. Then things that I might want to incorporate when I’m examining a patient, especially with that particular issue later on, so it has definitely I think helped my practice. … They have been trained in a slightly different way than we have. They’ve got a ton of knowledge in their area so being able to incorporate some of that is definitely helpful. (Fellow)

The fellows confirmed our observations that the team did not have to be physically around them in order for them to have access to it. It was instead mediated by lists, charts, knowledge bridging activities, and relationships: “I’d say more informally in the clinic just based on each case and what’s needed. Everybody comes in with their own expertise, and we find out a lot just by asking for help.” (Fellow)

Our observation that the case of a patient and the narrative around the patient was a compilation of various team member assessments, judgments, and interpretations was confirmed by fellows. One noted:

Patients tell different practitioners different stories about themselves. So, often, they’ll disclose something to the nurse or the dietician that they wouldn’t disclose to the physician or vice versa so that we could all work together to improve the care for the patient. … We may not have necessarily gotten that information just being the physician, doing our daily rounds. And so, I think communicating with the patient in those various ways or those various circumstances helps you to really care for them the best. (Fellow)

The structure of the clinic, the coordinating activities of staff, and access to multiple other relevant expertise underscored the cognitive richness and learning potential available to fellows: “A benefit that probably a lot of other centers don’t have.” (Fellow)

All staff recognized that they had something to teach fellows. In the process, fellows were able to experience the amplification of their clinical
reasoning and expertise through time spent time developing good team player habits. All members of the team dedicated time socializing fellows to this appreciation of team, and we saw a clear embodiment of IPC discourse being linked to better patient outcomes. Faculty held themselves to the same standards of cultural performance that they expected fellows to demonstrate:

There’s no “I” in team, right? No, truly and that we all have our personality differences, but I think one of the things that fellows really need to think about is back to just what I stated. Who wants to go to work with a pit in your stomach? You need to find a way to make it work to draw the best out of people, and if you do that, you get to work in the same place with a smile on your face for over 20 years as I have, seriously. (MD)

While organizational discourses of collaboration were aligned with the performance of team in our study context, the embodied practices we observed of collaborating to problem solve to provide what was perceived as better and safer patient care go beyond preparing medical trainees to get along with other health professionals.

Discussion

We have critically examined institutional mandates and processes related to IPC to understand the relationship between discourse, professional identity constructions, and learning. We contribute to the literature on how work place learning can be operationalized in subspecialty rheumatology curriculum development with examples of learning reinforced or challenged by IPC discourse. We have documented the potential afforded learners when professional, organizational, and embodied discourses are aligned. We have also shown that IPC, when role modeled in instances of problem solving, creates the conditions for explicit uptake of rationales for “getting along” that contribute to learning “why” collaboration is important for patient care. In other words, learners are developing adaptive expertise by building their conceptual knowledge of collaboration. The acuity of patient care in this complex setting has set the tone of cooperation and humbleness that is perceived by health care providers as generative and productive in the care of their patients. This is theoretically different from individuals ascribing duties associated with IPC to performativity—i.e., fulfilling organizational expectations of success. These findings hold implications for educators interested in reinforcing similar educational affordances in other clinical contexts.

First, a discourse of collaboration as a phenomenological reality emerged through the everyday practices of our participants. It made clinical good sense to practice in this way when caring for patients with rheumatological conditions. This suggests that teaching communication skills or how to collaborate in the abstract is not likely to generate the same embodied articulation of interprofessional practice we observed and more likely to mirror the performativity described in other studies as “paying lip service” to notions of team. Second, the willingness of team members to collaborate, in turn, fostered a commitment to learning that at times attenuated both intra and interprofessional power structures. While our analysis captured an array of complex and routine practices that enhanced the education of fellows, we also witnessed lingering sociocultural attributions of hierarchy that at times curtailed knowledge flow and integration. Attention to these politics are thus still important when thinking about the sociocultural elements that support collaborative decision making.

Third, when there is alignment between professional, organizational, and embodied discourses of IPC, learners are afforded new forms of learning important in the development of adaptive expertise. In our study, rheumatology fellows considered themselves learners not only in relation to their supervisors but often to other members of the interprofessional team. Staff role modeled the importance of collaboration in problem solving by frequently soliciting the opinions of other health professionals and tacitly encouraging fellows to do so as well. On occasion, a horizontal comradeship was visible where the physician performed the role of the learner in their interactions with fellows.

Lastly, our study describes IPC as a form of enacted problem solving that can occur with or without the physical presence of a team. How this occurs is important to consider when attempting to amplify conditions to reinforce the development of adaptive expertise. As we have shown while an IPC governmentality permeated the division of rheumatology at SickKids, its enactment was both temporally and spatially inflected. This flexibility allowed practices to evolve routines that “made sense” to them. In other words, forcing a team to display or perform their “teamness” together at all times can potentially undermine the embodiment of IPC discourse as good practice for patient.

Conclusions

The results from this study complement efforts to elaborate teaching and assessment frameworks related to collaboration competencies. In the process of explicating how collaboration is taught/modeled/reinforced in the workplace, we have described informal educational processes that align with organizational imperatives to emphasize team care and interprofessionalism.

While the value of collaboration is recognized, there are significant challenges inherent in operationalizing integrated interprofessional curricula. In particular, there is an imperative to provide discipline specific education to trainees as a fundamental starting point for integrative problem solving in a format that does not lead to knowledge stratification. Educational efforts to address this tension in the classroom or on the wards have included developing a common language of necessary competencies for being interprofessional. Adding to this line of thinking, our research has demonstrated that for health professionals to be successful, they must come to understand how collaboration relates to problem solving in relation to specific clinical problems and how to use strategically the ideas and practices associated with being interprofessional to deliver safe and relevant care to patients. Thus, for educators, when considering learning experiences and training sites for health professionals, a more purposeful selection of sites is essential for effective uptake and application of collaboration practices. In other words, educators should not assume that collaboration can be role modeled in any context or that learning derived from a specific collaborative context can be generalized.

Our work contributes to the literature that explores the intersections between
competence and collaboration. We have shown that when organizational and professional discourses of collaboration are aligned, there is increased likelihood that they will be embodied in the practice of care. Our study also documented ways in which trainees benefited from identifying learning opportunities from other health professionals, particularly learning that is not formally labeled as education or team learning. By applying a governmentality theoretical framework and using a data collection approach that combines text analysis, observations, and informal and semistructured interviews, we documented how subspecialty pediatric rheumatology trainees were socialized into a team orientation through exposure to day-to-day interactions that were not previously conceptualized by their training program to be part of their formal curriculum. We also documented the capacity to reinforce the development of adaptive expertise by explicitly role modeling how communicating across professions and attending to interprofessional relationships encourage a productive flow and integration of knowledge with the potential to enhance clinical problem solving.

Acknowledgments: The authors wish to thank all staff at the Division of Rheumatology, Hospital for Sick Children.

Funding/Support: This study was partially funded by a Royal College of Physicians and Surgeons of Canada, CanMEDS Research Development Grant.

Other disclosures: None reported.

Ethical approval: This study was approved by the Hospital for Sick Children Research Ethics Board (Study # 100045583).

Previous presentations: Preliminary results from this work were presented at the Department of Paediatrics, University of Toronto Education Day, March 2018, Toronto, Ontario, Canada, and at the National Health Care Hospital, May 23, 2018, Toronto, Ontario, Canada, and at Paediatrics, University of Toronto Education Day, this work were presented at the Department of Pediatrics and The Wilson Centre, University of Toronto, Ontario, Canada. ORCID: http://orcid.org/0000-0002-3575-2235.

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