Interprofessional Collaborative Practice in Primary Health Care in Aotearoa/New Zealand: A Discourse Analysis

Andrew Raymond Lynch

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Abstract

Interprofessional collaborative practice (ICP) has been identified as key to good primary health care (PHC) for decades. The release of the 2001 PHC Strategy in Aotearoa/New Zealand confirmed the importance of ICP in this country. An overview of the literature of ICP indicated there are varied and contested views of ICP and how it affects the work in PHC. Many frameworks and models of collaborative practice state effective ICP depends upon health care professionals being able to critically reflect on their practice. Drawing on critical hermeneutics theory this study explores how professionals working in PHC understand ICP and how they see reflective practice contributing to that understanding.

Semi-structured interviews were carried out with 20 participants working in varied PHC settings. Ten participants worked in one suburb of a small provincial town. The other ten participants were located in a different region. A sociology of knowledge approach to discourse analysis was used to analyse the texts from these interviews. This entailed carrying out a narrative analysis exploring the key objects, metaphors, plot, and values of the stories told in the interviews. This was complemented by an analysis of the place of ICP to consider influences of work environments. These two analyses informed a discourse analysis of the practices of ICP and reflective practice.

The potential benefits of interprofessional collaborative practice in primary health care are currently not being realised in this country. The study found a wide variety of ICP involving varied practitioners occurs outside of the dominant organisational infrastructure of the general practice. Yet the general practice, mainly staffed by GPs and practice nurses, remains at the centre of funding and policy infrastructure. Practitioners outside of the general practice invest much time and energy in building and maintain ICP relationships with practitioners within general practices as well as within other parts of the health system so as to provide better coordinated care for their patients. Significant changes to policy, funding and health system organisation are required to challenge the dominance of the general practice and enable ICP to flourish.

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Chapter 1 – Introduction

1.1 Introduction

Practitioners in primary health care (PHC) in Aotearoa/New Zealand often talk about the importance of collaborative practice with others, however, it is not clear whether everyone is talking about the same collection of practices. At a time when governments around the world are increasingly focusing on strengthening their health systems so as to better respond to increasing demands on health care, this has become especially important. One of the most frequently identified mechanisms to strengthen health systems is increasing collaborative practice, with the following definition of the World Health Organization (WHO, 2010) commonly referred to:

> Collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. Practice includes both clinical and non-clinical health-related work. (p.13)

Certainly, collaborative practice within PHC in Aotearoa/New Zealand has been a long-standing expectation both amongst individual practitioners and amongst provider organisations. The 2001 PHC Strategy identified the importance of establishing strong agreements, collaborations and networks of PHC providers so as to better serve the needs of local communities (King, 2001). Since the launch of the PHC Strategy this call for increased collaborative practices has been highlighted in a number of other strategy and policy documents with strong links being made to the rationale of providing better care. For example, the Health Information Strategy Steering Committee (2005) argued that implementation of their Health Information Strategy would "enhance the sophistication with which hospitals and primary care can begin to manage care, particularly chronic care, collaboratively" (p.19). They go on to note that this would result in "greater collaboration and sharing of information between hospitals, GPs, diagnostic service providers, pharmacies and other practitioners" (p.19).

In spite of these clear statements of the need for increased collaboration there remains much ambiguity about what is the nature of this collaboration and in particular what collaborative practices are. Much has been written about this confusion internationally

(Croker, Higgs, & Trede, 2009; D'Amour, Goulet, Labadie, San Martin-Rodriguez, & Pineault, 2008; Thistlethwaite, Jackson, & Moran, 2013). I argue that this lack of a shared understanding of collaborative practice in PHC within Aotearoa/New Zealand makes it extremely difficult to see how these practices can be strengthened. This is of particular concern in this country as the PHC system struggles to meet the current needs of communities in a health system that is increasingly seen as under strain.

An example of confusion in PHC is visible in the evaluation report of a pilot programme of teamworking and collaborative practice in PHC in Aotearoa/New Zealand (Boyd & Horne, 2008). In the report, the authors define the terms *interdisciplinary/ interprofessional* under one definition using the concept of collaboration, noting that these collective terms "describe approaches in which individuals from two or more professions work collaboratively to improve health outcomes" (Boyd & Horne, 2008, p.vii). Then throughout the rest of the report they use all the following terms interchangeably as if they are talking about the same concept: interdisciplinary, interprofessional, teamworking, collaboration and coordination.

1.2 The topic

Recognising the confusion associated with the use of the term collaborative practice, particularly within the PHC sector, this study is focused on exploring the understanding of this term held by different PHC practitioners in Aotearoa/New Zealand. Establishing further clarity on how collaborative practice is understood by current practitioners in the field will create a firmer foundation upon which collaborative practices can be consolidated in the future. In Chapter Two literature on collaborative practice is synthesised and discussed.

Whilst reviewing literature on collaborative practice it became clear that many frameworks and models of collaborative practice identify strong relationships between collaborative practice and reflective practice. Authors note that difficulties with collaboration occur when practitioners do not critically reflect on their own ways of seeing and enacting care. Indeed, Orchard et al. (2005) argue that to collaborate with others health professionals must "learn to accept a blurring of practice boundaries and trust other discipline members in sharing patient care processes" (p.5). Other areas of reflection are also identified as integral to collaborative practice including critically reflect on: their practice with clients/patients; their professional identity; their relationships with other professionals and organisations that are providing care; and the place of power in the caring relationship.

Consequently, a further literature review of reflective practice (RP) was undertaken paying particular attention to the connections between RP and collaborative practice. This literature is discussed in Chapter Three.

A decision was, thus, made to explore PHC practitioners' understanding of interprofessional collaborative practice (ICP) in the context of PHC in the first instance, and then their perspectives on how RP contributes to and advances ICP.

1.3 My epistemological/ontological position

The decision to focus on the understanding that different practitioners have of interprofessional collaboration was key in the consideration of adopting a hermeneutic approach to this study. Hermeneutics is increasingly being acknowledged in qualitative research as making a significant contribution to the field (Alvesson & Sköldberg, 2009; Brinkmann, Jacobsen, & Kristiansen, 2014; Diesing, 1991; Kinsella, 2006). The relevance of a hermeneutic approach to this study was reinforced by considerations of the multiple perspectives of ICP likely to be encountered given the range of professions working in PHC and the range of different contexts within which they work. As noted by Kinsella (2006) a hermeneutic approach has five main characteristics: a) it seeks understanding rather than explanation; b) it considers the situated location of interpretation; c) it recognises the role of language and history in interpretation; d) considers inquiry as conversation; e) it is comfortable with ambiguity. These were all key considerations for this study.

An important foundation of hermeneutics is that the interpreter is not an impartial observer, but they bring their own background understanding of the world and the dialogue into how they interpret what they encounter. This is discussed further in Chapter Four. I note here some key features of my own background that I was constantly bringing into awareness as I undertook the hermeneutic interpretation. I am a social worker by profession and have worked in health organisations in the not-for-profit and public health sectors. In the early 2000s I worked for a public health unit on a regional (and then later a national) project focused on embedding rigorous planning and evaluation of health promotion into the Primary Health Organisations in this country. The project came about as a result of the implementation of the 2001 Primary Health Care Strategy (King, 2001). This experience raised my awareness of the potential place for PHC to transform the wellbeing of our communities in Aotearoa/New Zealand. This realisation led to ongoing conversations with many people on the potential contributions to PHC by a range of practitioners including

nurses, social workers, community developers, and health promoters. Particularly significant dialogue on this topic occurred with my life partner, who is a physician and liaises frequently with general practitioners in primary health care.

In a previous study I had drawn upon the critical hermeneutics theory of Hans Herbert Kögler (1996; 1997a; 1997b). Kögler's theory draws together the hermeneutic perspective of Gadamer, focusing on interpretation as dialogue, with the work of Foucault, who focuses upon the ways discourses are produced through power/knowledge relations. Foucault's analyses of discourses in health are widely acknowledged as offering much insight into researchers' examinations of the phenomenon of the medicalisation of health and the power relations operating in the contexts of biomedicine (Petersen, 2012).

A final decision to utilise Kögler's critical hermeneutics theory was made when it became clear that many of the key concepts of his theory have a strong resonance with the conceptual frameworks of ICP and RP, for example: the importance of acknowledging the subjective experience of another person; the need to explore how the context of interactions influences the individual's perceptions; the relationships between the individual's perceptions, the context of their present interactions and their previous understandings and experiences; the relationships between language, power and the meanings attached to experiences; the relationships between knowledge, societal structures and subjective experience; and finally, the importance of different reflexive modes and how these may lead to exploring social goals in quite different ways. Kögler's theory is discussed more fully in Chapter Four.

1.4 Methodology

Adopting a hermeneutic approach to research inherently means there is a focus on text. The primary text used for analysis in this study was generated from semi-structured interviews with a variety of professionals working in PHC. An interview guide was developed after considering the literature on interprofessional collaborative practice and RP. A purposeful sampling strategy to recruit participants was utilised. This approach was guided by Laverty (2003) who notes that selection of participants in hermeneutics studies focuses on choosing people who have lived experience of the topic being researched and who are different enough from each other "to enhance possibilities of rich and unique stories of the particular experience" (p.18).

Two study sites were chosen in different regions of Aotearoa/New Zealand. Recruitment at Site One, in a small provincial town, began with interviews of a GP in a general practice and a nurse practitioner working within a community-based Māori health provider. Recruitment at Site Two began with a group interview with two nurses and one kaiāwhina who worked on a community-based support programme for people living with long-term conditions[1] (LTCs). The people on the programme operated across a large geographical area encompassing a number of towns and cities. Further details on the sampling decisions are detailed in Chapter Five. Ultimately 10 practitioners at each study site were interviewed.

Adopting a critical hermeneutics approach to this study meant analysis needed to attend to the importance of language and manifestations of power. This informed the decision to adopt Keller's (2005; 2013) *sociology of knowledge approach to discourse analysis* to frame analysis. This analysis ultimately took three main forms: a narrative analysis which forms the basis of Chapter Seven; an analysis of the place of PHC which is discussed in Chapter Eight; and finally a discourse analysis (which draws upon the previous analysis chapters) which is presented in Chapter Nine.

The study set out to answer the following questions:

1. What do health professionals working in PHC in Aoteaora/New Zealand mean when they talk about ICP?

2. In what ways do health professionals working in PHC in Aoteaora/New Zealand see RP contributing to or advancing ICP?

3. How have wider discourses of PHC shaped the meanings of ICP and RP as articulated by health professionals working in PHC in Aoteaora/New Zealand?

1.4.1 Participant recruitment and connections to the iCOACH study

Initially, this study was linked to a large international research programme entitled Integrated Care for Older Adults with Complex Health Needs (iCOACH) that was investigating innovative models of integrated care in community-based settings. There was an expectation that my findings would contribute to those of iCOACH and I could benefit

[1] LTCs are defined as "any ongoing, long term or recurring condition that can have a significant impact on people's lives" (Ministry of Health, 2019). LTCs are also referred to as chronic conditions or non-communicable disease. Common examples of LTCs affecting older people include: diabetes, cardiovascular diseases, mental illnesses, and respiratory diseases.

from insights from the iCOACH study. iCOACH selected three community-based primary health care (CBPHC) case studies in Aotearoa/New Zealand for the second phase of their research programme which focused on identifying critical success factors in introducing innovative models of care.

In the early implementation of my recruitment, however, it became clear that information-rich cases pertaining to my research topic were more likely to be obtained by following connections to professionals who were outside of the original iCOACH case studies. Additionally, it became increasingly clear that the theory informing my approach diverged from that underpinning the iCOACH study. Negotiations with the iCOACH team resulted in the establishment of a recruitment process for my research which began with the connection to practitioners in the iCOACH case studies but enabled me to follow meaningful threads of interprofessional collaborative practice beyond these case studies. In this way I was able to act reflexively to shape and form the sample of practitioners so as to best capture wide and meaningful collaborative relations. At this stage ethical approval was sought, and obtained, to recruit in a slightly different manner which I explain in detail in Chapter Five. Nevertheless, early connections to iCOACH provided important entry points to particular communities of practitioners for this study.

1.5 Layout of the thesis

Chapter Two discusses the literature of interprofessional collaborative practice (ICP). The importance of ICP to PHC is discussed before outlining some of the difficulties in conceptualising ICP. In spite of these difficulties some theorising and conceptualising of ICP has been carried out and a critical overview of this is provided. The increasing significance of competency frameworks is also discussed here as these are beginning to shape the ways that ICP is influencing the development of the future health professional workforce.

The place of reflection in the conceptualisation of ICP is evident in ICP competency frameworks, so in Chapter Three the literature of RP in PHC is discussed. The use of RP in the health professions has a long history and three main discourses of RP were identified in the literature and are elaborated as they relate to the dominant professions of medicine and nursing in PHC. The potential contributions of RP to ICP are identified but it is noted that these contributions are not currently well-developed in literature.

Chapter Four lays out the rationale for drawing upon Kögler's critical hermeneutics as the theoretical foundation of this study. The decisions on methodology, methods and

research design which are discussed in Chapter Five were strongly influenced by this critical hermeneutics. A particularly important part of the discourse analysis approach adopted in this study is a consideration of the influences of context upon the meanings of ICP. This consideration is addressed in Chapter Six where key aspects of the landscape of PHC in Aotearoa/New Zealand are discussed. The discussion considers the historical, cultural, organisational and policy landscapes that provided a context for the discourse analysis of the following chapters. This consideration of context in relation to the findings of the studies is presented in Chapter Eight.

Chapters Seven, Eight and Nine collectively comprise a presentation of findings and analyses. Chapter Seven presents the narrative analysis carried out which provided the foundation for the discourse analysis. The narrative analysis adopted in this study is informed by Keller's sociology of knowledge approach to discourse analysis which is elaborated in Chapter Five. The focus was on identifying narratives that were typical of the discourses being identified in the texts. The findings and analysis of Chapter Eight builds upon the narrative analysis and focuses on the connections between people, their health and place. In Chapter Eight the findings from this study that ICP in PHC occurs in multiple places is considered in light of dominance of the place of the general practice in PHC. Chapter Eight, thus, provides an important step towards the discourse analysis presented in Chapter Nine. Three discourses of ICP in PHC were identified in this study alongside three discourses of RP in PHC. These are presented and discussed in Chapter Nine. Finally, Chapter 10 outlines the conclusions that can be drawn from this study and suggests the implications for the future of PHC in Aotearoa/New Zealand. Strengths and limitations of the study are discussed pointing to future research possibilities.

Chapter 2 – Interprofessional collaborative practice in primary health care

2.1 Introduction

In Aotearoa/New Zealand an expectation of collaborative practice has been named for several decades as an important innovation in a range of PHC strategy and policy documents. Section 2.2 of this chapter provides an overview of commonly articulated arguments for increasing collaborative practice in PHC. Then in Section 2.3 the barriers that stand in the way of the implementation of such practices are discussed. The dominance of the medical profession in health care sits at the centre of these barriers, however, there are a number of tensions between professions with regard to professional identity and role socialisation which are also discussed.

Compounding the above difficulties in implementing collaborative practices in PHC are three main areas of confusion: the varied and interchangeable use of similar, but not identical terms when purportedly referring to the same sets of practices; differentiating collaborative practices from related concepts (e.g. teamworking); and clearly identifying who is collaborating with whom when we are considering collaborative practice in PHC. These three areas are discussed in Section 2.5. In spite of the aforementioned barriers and difficulties in implementing collaborative practice, some theorising and conceptualisation of interprofessional collaborative practice has been undertaken. Section 2.6 outlines this work. The chapter concludes with an overview of the increased attention being paid to collaborative practice competency frameworks within curricula of a range of health professionals.

2.2 Arguments for interprofessional collaborative practice in PHC

The arguments for increasing interprofessional collaborative practice in the wider health sector are many. These primarily centre upon a need to respond to one, or a combination, of these four problems: changing demographics due to the ageing of the baby boomer generation[2]; an increasing number of people with LTCs; shortages in particular health professionals in certain areas; and increasing complexity in health systems (Karam, Braultb, Van Durmea, & Macq, 2018). In responding to these problems governments are

[2] Baby boomers are the demographic cohort born between 1946 and 1964.

increasingly focused on better containing the costs of health systems. Finding ways to more efficiently and effectively manage the limited resources available in health systems has become key. Particular attention in the next two paragraphs is paid to the first two of these four problems (the ageing baby boomer generation and the increasing number of people with LTCs) with regard to PHC. The latter two problems (shortages of health professionals and the complexity of the health system) are discussed in Chapter Six.

The ageing of the baby boomer generation is placing pressure upon health systems around the world, as older people have a higher incidence of LTCs. WHO (2005) names this rising incidence of LTCs as one of the most significant health problems that countries will face this century. Although the challenges to health care systems from this growing incidence of LTCs will be broad, it is the impacts upon PHC systems which are receiving particular attention (Nuño, Coleman, Bengoa, & Sauto, 2012). PHC systems world-wide are organised around acute problems and the urgent needs of patients, and as such are poorly equipped to respond to the ongoing management of LTCs (World Health Organization, 2002; 2005). Incorporating interprofessional collaborative practice into health care systems, it is argued, aids responses to LTCs (Barr & Low, 2013; Frenk et al., 2010; Quinney & Hafford-Letchfield, 2012; Sims, Hewitt, & Harris, 2014).

The health workforce is also made up of a large proportion of people in the baby boomer generation. Concerns internationally of health workforce shortages are mirrored in New Zealand. In PHC this is of particular concern with the Royal New Zealand College of General Practitioners (2017) noting "57% of GPs are aged 50 years or older, that 44% of GPs intend to retire within the next 10 years and that half of these respondents plan to reduce their hours within the next five years" (p.2). The rural PHC GP workforce is especially affected with a slightly higher proportion of rural GPs being in the 65–69 year age group (p.7). The nursing workforce in New Zealand displays a similar demographic profile to doctors with the average age of the nursing workforce being higher now than in past decades; by 2015, 45% of nurses were aged over 50 (Ministry of Health, 2016, p.11). A similar rural/urban pattern to doctors is also visible, with nurses in rural areas more likely to be older.

Health systems around the world are exploring new models of care and changes to the skill-mix of the health care workforce to better respond to these problems of population changes and workforce shortages (Buchan, Ball, & O'May, 2000; Frenk et al., 2010; Nelson, Martindale, McBride, Checkland, & Hodgson, 2018). Interprofessional collaborative

practice lies at the heart of many of these changes with claims that it can assist with managing escalating costs in health care (Gilbert, Yan, & Hoffman, 2010; Ministry of Health, 2009), can result in improved quality of services (McCallin, 2001), can reduce length of hospital stays, and enhance patient/client safety (Sims et al., 2014). However, there is an ongoing need to consolidate this evidence, with a Cochrane systematic review concluding it is less clear whether ICP improve patient-assessed quality of care and continuity of care (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). Though the same review does confirm: "strategies to improve interprofessional collaboration between health and social care professionals may slightly improve patient functional status, professionals' adherence to recommended practices, and the use of healthcare resources" (Reeves, et al., 2017, p.2).

As health systems have implemented new models of care that incorporate ICP they have developed new roles (e.g. nurse practitioners, nurse prescribers, pharmacist prescribers) and reviewed the ways existing roles operate. These processes are collectively named skill-mix changes and fit into four broad areas: enhancement, substitution, delegation, and innovation. Nelson et al. (2018) succinctly describe these:

> Enhancement (for example, extension of a primary care practice nurse's role without need for supervision); substitution (for example, a less expensive prescribing pharmacist expanding their role into the medical domain to substitute partially for a GP); delegation (for example, a GP transferring tasks to a physician associate under supervision); and finally innovation (for example, a physiotherapist leading musculoskeletal clinics that provide a new/enhanced service in primary care). (p.66)

There is growing evidence of benefits to be gained in PHC with these skill-mix changes (Nelson et al., 2018; Sibbald, Shen, & McBride, 2004). In implementing this study attention was paid to the possible occurrences of these skill-mix changes and their potential connections to ICP.

In their systematic review and meta-analysis of the substitution of doctors' work by nurses in PHC, Martinez-Gonzales et al. (2014) found "that nurse-led care is associated with higher patient satisfaction, lowered overall mortality and lowered hospital admissions" (p.14). However, there remain complexities about how different practitioners from different professional groups will increasingly work collaboratively with each other as is hoped. Placing other less expensive professionals into our PHC system (like nurse practitioners or pharmacist prescribers) may not lead to increased interprofessional collaborative practice). Nelson et al. (2018) caution: "The replacement of GPs with less expensive non-medical professionals may result in supplementation rather than substitution, leading to a range of

unintended consequences. These include reduced productivity/ continuity of care and increased demand/costs" (p.67). In short, these changes may not lead to increased interprofessional collaborative practice.

2.2.1 Health workforce reform in primary health care in New Zealand

The international patterns of changes in demography and health workforces discussed above have also been visible in New Zealand and contributed to significant policy reform of New Zealand's PHC sector. Although the landscape of this policy reform is discussed in more detail in Chapter Five, I note here some particular connections to skill-mix change as discussed above. Concerns about the mismatch between health workforce demand and supply in New Zealand were documented in the late 1990s and early 2000s. Reforms of the health sector, particularly the release of the 2001 Primary Health Care Strategy, around this time were informed by these concerns and signalled the importance of different professionals collaborating with each other to provide care. Since that time changes to health policy have continued to support a range of initiatives which have included elements of role expansion, substitution, delegation and enhancement. This has resulted in roles like nurse practitioners and pharmacist prescribers being increasingly incorporated into PHC systems.

To enable full implementation of these roles in PHC, a number of legislative, funding, and practice changes have been required in New Zealand with the pace of these changes building across the latter part of the 2000s. A particularly significant chapter in these changes was the passing of the 2016 Health Practitioners (Replacement of Statutory References to Medical Practitioners) Act which resulted in changes to eight other Acts: Primarily these replaced the term 'medical practitioner' in these Acts with the term 'health practitioners who are suitably qualified.' In essence this has meant that other practitioners like registered nurses, designated prescriber-registered nurses, nurse practitioners and pharmacist prescribers can now undertake work that was previously only allowed to be done by doctors (role substitution). Consequently, these other suitably qualified health practitioners are now able to carry out statutory responsibilities like issuing certificates of proof of illness or injury, participating in ACC claimants' individual rehabilitation plans, or issuing medicine standing orders. The extent to which these changes have resulted in increased interprofessional collaborative practice in PHC in this country is not clear.

2.3 What stands in the way of interprofessional collaborative practice?

In spite of the arguments for interprofessional collaborative practice, health systems struggle to move beyond older established models which centre upon particular professions carrying out tasks discretely from others. Much has been written about the challenges to implement more collaborative interprofessional ways of working. Three commonly identified areas of difficulty are the dominance of the medical profession, tensions between professions related to professional identity, and limited understanding of the roles and responsibilities of other professions.

2.4 Dominance of the medical profession

Since the development of the professions, medicine has held a dominant position that reinforces class and gender advantages (Hall, 2005). Organisational and policy infrastructure have shored up this position. As new professions have developed over the past 100 years, medical discourses have continued to hold dominance. For example, Baker et al. (2011) explain how medicine has maintained a dominant role in defining the areas of competence of other professions (like nursing and midwifery) and in so doing medicine has staked out its own claims to resources, role boundaries, decision-making power and professional development opportunities. Orchard, Curran and Kabene (2005) argue that the furthering of ICP necessitates changes to this medical dominance: "Collaboration based on a relationship of interdependence, built on respect, trust and understanding of the unique and complementary perspectives of each profession cannot occur without resolution of this power imbalance" (p.5). It became clear in the course of the interviews in this study that the dominance of the medical profession is a key consideration of this study and is discussed further in Chapter Six.

2.4.1 Professional identity

A common barrier to ICP relates to professional identity conflicts. McNeil, Mitchell and Parker (2013) explain that professional identity "manifests itself in terms of how members of a profession categorise and differentiate themselves from members of other professions" (pp.292–293). This identity is developed through complex processes of socialisation, education and enculturation. Through these social processes, different professions develop their own set of values and interpretations of what health care is, and what roles they carry out to provide this care. At the same time, socialisation reinforces particular views about the roles and responsibilities of other professions (Reeves, et al.,

2017). Difficulties with collaboration occur when practitioners do not critically reflect on their own ways of seeing and enacting care. Indeed, Orchard et al. (2005) argue that to collaborate with others health professionals must "learn to accept a blurring of practice boundaries and trust other discipline members in sharing patient care processes" (p.5).

2.4.2 Tribal turf wars

Both of the above areas of difficulty (those perpetuating the dominance of the medical professions and the socialisation processes that differentiate particular professional identities in relation to others) can work alongside other processes that interfere with collaboration. These processes can result in professionals seeing the roles and responsibilities of others as less important or less relevant than their own roles, and can result in actions that minimise the involvement of others in health care (Orchard et al., 2005). For example, in addition to the processes of medicine dominance described above, the professions of medicine and nursing within PHC can together marginalise the input from other professions like pharmacy, social work, physiotherapy, counselling, and podiatry. Baker et al. explain:

> Historically, these [other] professions have been 'clustered together' into a homogenous group of health care providers (sometimes referred to as 'allied health') on the basis of not being nurses or physicians, a position which arguably negates the unique status and contributions to patient care for each of these professions. (Baker et al., 2011, p.103)

Thus the mechanisms which help establish professional identity can also lead to exclusionary strategies which minimise the importance of these other professions in health care. Practitioners can engage in what Baker et al. (2011) refer to as *elbowing activity*, where they push others aside to consolidate their own role in providing care, and their own place in the power hierarchy of health care.

These three barriers to interprofessional collaborative practice have been longstanding and are difficult to resolve. In 1972 the Institute of Medicine (IOM) published their report from the first national American conference focusing on the interrelationships of educational programmes for health professionals. They identified a number of structural and organisational obstacles in the movement towards increased interprofessional (interdisciplinary) collaborative practice. It is significant that more than 40 years later, two of these remain as fundamental problems impeding interprofessional collaborative practice. First is the rigidity of professional boundaries: "excessive professionalism, inappropriate

defence of prerogatives, and status-striving create major impediments to any future efforts" (Institute of Medicine, 1972, p.27). Second, "too much emphasis is given to the issues of the captaincy of the team and the mechanism of delegation of task and not enough to optimizing the contribution of each profession to the total effort" (p.28).

2.5 Difficulties in conceptualising interprofessional collaborative practice

Having summarised above the main arguments which support the importance of collaborating with others to provide healthcare, I now outline three significant barriers to collaboration. In this section some of the difficulties in the conceptualisation of ICP are discussed. At the centre of these difficulties is the variety of different terms commonly used to describe apparently similar or comparable practices. Additionally, the same, or similar, terms will often be defined, or used, in different ways, confounding a shared understanding of interprofessional collaborative practice (Croker et al., 2009; D'Amour et al., 2008; Thistlethwaite et al., 2013). Indeed, the *Journal of Interprofessional Care* (2019) have provided a two-page glossary of terminology to support submissions to their journal because of this "ongoing terminological uncertainty within the interprofessional field" (p.1). Consequently, it is not always clear that policy makers, managers, professional leaders, educational institutions, researchers and practitioners are talking about the same thing when discussing collaborative practices of people working in healthcare.

2.5.1 Confusion in the use of terminology

The following commonly cited definition provides a good initial example of the ways that different terms can be used to describe concepts that are purportedly the same.

> Interprofessional practice is used interchangeably with collaborative practice throughout this project, and both are defined by the WHO's definition for collaborative practice: 'when multiple health workers from different backgrounds work together with patients, families, carers and communities to deliver the highest quality care.' (WHO, 2010, p.7)

Commonly, the phrases that describe the ways people in health care work collaboratively with others are constructed in the following manner. One of three main prefixes (inter-, multi-, trans-) is added to a primary stem (commonly the adjectives disciplinary or professional), and then combined with a term/phrase which defines the focus of collaboration (see Table 1). This results in a range of different phrases which have been defined in various ways across time and are often used interchangeably. Some common

phrases used are multi-professional team, transdisciplinary collaboration, or interprofessional collaborative care. Particular institutions tend towards utilising one phrase over others and have developed their own clear arguments for this usage.

Table 1

Common units of comparable terms for interprofessional collaborative practice

Prefix	Main adjective	Focus
Multi-	Disciplinary	Collaboration
Inter-	Professional	Cooperation
Trans-		Collaborative care
		Collaborative practice
		Team
		Teamwork

2.5.1.1 Varied use of prefixes

Discussions on the use of one prefix over another do not always accord the same meaning to differentiation between the prefixes. In one argument the terms are considered as being on a continuum which describes increasing degrees of collaboration: from uni-professional → multi-professional → inter-professional → trans-professional (Kvarnstrom, 2008). However, the nature of the relationships between those collaborating is not always clear from descriptions put forward to justify utilising one prefix over another.

For example Rawson (2002) suggests that: "'trans' signifies relationships across or beyond but does not carry any indication of mutuality" (p.40); whereas the IOM (2014) uses the prefix trans- to describe "multiple professions working together under a shared model with a common language (transdisciplinary)" (p.15). Neither of these definitions aligns closely with the definition in the glossary of terminology published by the Journal of Interprofessional Care: "transdisciplinary is an activity designed to promote generic working: a process whereby the activities of one discipline are undertaken by members of another" (Journal of Interprofessional Care, 2019). D'Amour and Oandasan (2005) discussing distinctions between the terms multidisciplinary, interdisciplinary and transdisciplinary conclude, "it became clear that such terms are rarely clearly defined and they are often used interchangeably" (p.120).

2.5.1.2 The main adjectival stem: Disciplinary or professional

In the examples above it is clear that the adjectives disciplinary and professional are both commonly used as parts of phrases describing collaborative practices. More than 20 years ago Baldwin (1996) wrote an historical overview of this field and suggested that the terms inter-disciplinary and multi-disciplinary held particular sway prior to the 1970s, but from the mid-1970s onwards the term interprofessional became increasingly utilised. He concludes his overview noting: "while both terms continue to be used, at times almost interchangeably, more recent emphasis has been placed on the functional terms: 'teamwork' and 'collaboration'"(p.183). Twenty five years later this usage continues. Indeed, I argue in Section 2.5.2.1 that usage of the terms teamwork and collaboration, which Baldwin saw as potentially helpful, has itself been confounding.

A common argument against utilisation of the term disciplinary is that this term is used in different ways within academia and some professional fields (Barr, Koppel, Reeves, Hammick, & Freeth, 2005). For example, in academia it is used to differentiate between academic groups that draw upon particular bodies of theory and methods. In the professions it is used to identify sub-specialities of expertise rather than differentiating between professions (e.g. in medicine community child health is a different sub-speciality to paediatrics). Nevertheless, the term disciplinary is the one most commonly used by the IOM in their multiple contributions to the field. The IOM organised the first national conference on interdisciplinary practice in 1972 which brought together people at a national level from diverse fields to consider how better to prepare professionals for this type of practice (Institute of Medicine, 1972); then continued to run similar events across many years.

On the other hand it is argued that the term interprofessional excludes people in health care teams who are not classified as professionals – like community health workers, nursing assistants, and project managers (Drinka & Clark, 2000; Orchard et al., 2005), as well as clients/patients and their care-givers/family (Hammick, Freeth, Copperman, & Goodsman, 2009; Hoffer Gittell, Godfrey, & Thistlethwaite, 2012). Inclusion of clients/patients in definitions of collaborative practice has become increasingly important as health systems redefine themselves as patient-centred. This conceptualisation of patient-centred health care is discussed further in Section 2.8 as a part of the discussion on competency/capability frameworks.

Some definitions avoid use of either of these initial stem words by referring more simply to collaborative practice (Gilbert et al., 2010) or using other similar phrases (see the final column of Table 1). However, this usage does not always resolve who is being conceptualised as collaborating with whom. This dilemma is explored further in Section 2.5.3.

2.5.2 Interprofessional education, learning and practice

As the momentum for interprofessional collaborative practice has mounted, the need for tertiary education institutions, who train/educate professionals, to incorporate this content into their curricula has increased. This attention to interprofessional education and learning has contributed a further set of terms. Kitto et al. (2011) argue that in spite of the fluid nature of many of these further phrases, the following three are increasingly recognised internationally:

- Interprofessional practice: "health/social care professionals working together as a team with a common purpose, commitment and mutual respect";
- Interprofessional learning: "learning arising from interaction between members (and/or students) of two or more professions";
- Interprofessional education: "occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care" (pp.2–3).

In the 2000s several countries established collaborative endeavours across faculty and institutions that educate various professionals to consider the minimum interprofessional collaborative competencies that they wished their graduates to possess. The resultant frameworks of competencies for interprofessional collaborative practice are outlined later in Section 2.8.

2.5.2.1 Differentiating collaborative practice from related concepts

Authors do not always make clear distinctions between the concepts collaboration, teamwork, and teams; or, if they do distinguish between these concepts they do not necessarily accord them the same meaning or position in relation to each other. For example, Sims et al. (2014) identify collaborative practice as one of 13 processes or mechanisms underlying day-to-day functioning of teams. They explore the evidence for these

mechanisms and conclude there is evidence that collaboration does lead to better outcomes for teamwork.

In contrast, Reeves, Lewin, Espin and Zwarenstein (2010) conceptualise collaboration as separate from teamwork. They identify four forms of interprofessional work, these being collaboration, teamwork, coordination and networking. Reeves et al. (2010) go on to elucidate this separate categorising of collaboration from teamwork, noting that with collaboration there is more unpredictability than in teamwork with regard to clarity of goals, collective tasks and the roles of individuals. The authors suggest that notions of collaboration, rather than of teamwork, are of more relevance to PHC as the multiple providers of services related to ongoing integrated care are less likely to be confined to one formal organisational team.

It is certainly common for descriptions of interprofessional collaborative practice to focus on the establishment of teams and the importance of teamwork. In the section below on competency/capability frameworks this is particularly visible. However, utilisation of the terms 'team' and 'teamwork' does not always mean that authors are discussing interprofessional collaborative practice, even when the team comprises practitioners from different professions. That is, explorations of team composition, the structuring of teams, the collaborative activities of team members, and the settings of the team, "do not help us understand what transpires in the working lives of a group of collaborating professionals or the nature of their interactional dynamics" (D'amour & Oandasan, 2005, p.126). Indeed, more than 20 years ago, Baldwin (1996) reminded us that interprofessional health care teams are "not an end in themselves, but a means for more effective communication and cooperation among health professionals in the service of patient needs" (p.183). As such, Baldwin suggests that our focus is best directed towards collaboration rather than on the team itself. Baldwin's argument has been an important consideration for my focus upon collaboration, rather than upon teams and teamwork.

Reeves et al. (2015) also support the idea of teasing out the differences between interprofessional collaboration and teamwork. They suggest that the notion of interprofessional collaboration might be better described as 'interprofessional knotworking' and in their research with ICU staff explain: "Such an approach acknowledges that interprofessional interactions are more like threads of activity, which are tied and untied between different ICU staff, rather than traditional approaches to teamwork which involve regular and more collaborative interaction" (Reeves et al., 2015, p.235). This description of

collaborating as threads of activity that are tied and untied sits in contrast to the nature of teamwork, which is more commonly identified as fixed in the organisational system.

Certainly a focus on 'teams' may divert our attention away from the group collaborative effort which can emerge amongst people who are not 'in' a team (Kitto, Chesters, Thistlethwaite, & Reeves, 2011). Indeed, not only do people collaborate with others in their organisation who are not in an allocated work team, but they can also collaborate with people from other organisations. This is especially so in PHC contexts such as in the development of shared-care pathways and, more recently, calls from funders for demonstration of inter-organisational collaborations[3].

A further aspect of confusion in terminology relates to conflating of the terms integration and collaboration. For example, Sunderji et al. (2018), in their systematic review of educational interventions to train psychiatrists in integrated care use the terms interchangeably: "Integrated or collaborative care is a well-evidenced and widely practiced approach to improve access to high-quality mental health care in primary care and other settings" (p.513). Boon, Mior, Barnsley, Ashbury and Haig (2009) suggest that the common pattern of using these two terms as if they were interchangeable needs to change. They argue that good integration requires collaboration but collaboration does not require integration. The implementation of integrated care pathways in PHC provides an example to illustrate this point. Integrated care pathways are "pre-defined management plans for a particular symptom cluster, diagnosis or intervention that aim to make care more structured, consistent and efficient" (Greenhalgh, 2007, p.255). Greenhalgh (2007) argues that the integration of these integrated care pathways only works when "they are developed collaboratively with input from both primary and secondary care by doctors, nurses, other health professionals, administrators, technical staff and – increasingly – lay experts (patients and carers)" (p.256).

2.5.3 Who is collaborating with whom?

In the above two sections I have noted some examples of who is considered to be collaborating with whom in different manifestations of interprofessional collaborative practice. In this section I explore this dimension further. Discussions of interprofessional collaborative practice do not consistently include the same groups of people as collaborators (see Table 2). When different groups of people collaborate, the framing of the nature of the

[3] e.g. in New Zealand with the PHO Integrated Performance and Incentive Framework (IPIF).

collaboration can change. For example, Kitto et al. (2011) note that "in primary care settings interprofessional practice can be less formalised and more diverse" (p.4).

Table 2

Potential collaborators with PHC professionals

- clients/patients and their care-givers/families
- representatives of community groups that clients/patients work and live within
- other practitioners working within a designated health care team within the PHC organisation
    - people in the same profession e.g. nurses collaborating with nurses
    - people in other professions e.g. nurses collaborating with doctors
- other practitioners within the health care organisation but not in a designated team
- practitioners from other health organisations
    - from the same professional group
    - from other professional groups or non-professional groups
- practitioners from non-health organisations (e.g. social service organisations)

A common way of conceptualising the nature of the collaborative relationship and who is being collaborated with, utilises the notion of partnering. Three particular sets of relationships are commonly identified: partnering with patients; partnering with other health care practitioners; and partnering with communities (Institute of Medicine, 2001; Orchard et al., 2005; World Health Organization, 2005). For example, Orchard et al. (2005) argue "true interdisciplinary practice is defined as a partnership between a team of health professionals and a client in a participatory, collaborative and co-ordinated approach to decision making" (p.1). Similarly, Barr and Low (2013) incorporate the notion of partnership into their definition of collaborative practice, though they broaden the scope of who is included in this partnering relationship: "Collaborative practice is working in partnership between professions and/or between organisations with individuals, families, groups and communities." (p.3). This naming of the importance of collaboration with patients/clients and their families/care-givers is strongly connected to the patient-centred (care) movement.

The IOM (2001) propose that patient-centred care is an essential component of quality improvement for health organisations. They argue it is founded on partnerships between patients, practitioners and families and defined as "care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions" (IOM, 2001, p.40). The patient-centred (care) movement has impacted significantly on the development of the competency frameworks of interprofessional collaborative practice discussed further below.

As argued above there are clear international and national calls for increasing interprofessional collaborative practice, particularly within PHC contexts, in assisting with preventing hospitalisations related to LTCs. There remain many questions about what this collaborative practice looks like, who it involves, and how practitioners in the workplace view such practice. Yet, some theorising and conceptualising of ICP has been undertaken.

2.6 Theorising and conceptualising interprofessional collaborative practice

In spite of the three main areas of difficulty in conceptualising ICP identified in Section 2.5 above a number of conceptual frameworks and competency frameworks have been developed. The frameworks are not easy to compare as they often draw upon different theoretical paradigms and are influenced by the different organisational/ practitioner contexts within which they were developed. Nevertheless, in this section common themes in the frameworks are discussed drawing particularly on the work of D'Amour, Ferrada-Videla, San Martin Rodriguez and Beaulieu (2005) and Karam, Brault, Van Durme and Macq (2018) to shape this section.

D'Amour et al. (2005) carried out a literature review of interprofessional collaborative practice frameworks and identified seven theoretical frameworks which met their three evaluative criteria: being based upon empirical data; incorporating a review of literature; and founded on explicit theory. Explicit theory the frameworks draw upon include: social psychology, organisational theory, cognitive theory, sociology of knowledge, and management theory. Across the frameworks, D'Amour et al. (2005) discerned five common themes within the frameworks that group key concepts of collaboration: sharing, partnership, interdependency, power, and collaboration as an evolving process. These themes occur commonly in the literature and so are used to structure a further elaboration of these concepts in this section.

Karam et al. (2018) carried out a systematic review examining the conceptual frameworks of interprofessional and interorganisational collaboration in the field of health care. Their synthesis included 16 qualitative articles published between 2004 and 2014. The resulting analysis identified the importance of the following concepts for interprofessional collaboration: communication, trust, respect, mutual acquaintanceship, power, shared goals, consensus, patient-centredness, task characteristics, and environment (p.81).

Utilising the themes identified above to organise material, an analysis of the following conceptualisations and models of ICP was carried out to identify common

concepts: Bronstein's *Model of Interprofessional Collaborative Practice* (2003; Mellin et al., 2010); the *Conceptual Model for Patient-Centred Interdisciplinary Collaborative Practice* of Orchard, Curran and Kabene (2005); D'Amour's structuration model of collaboration (2008); the systematic review of interprofessional and interorganisational frameworks by Karam et al. (2018); and Petri's (2010) concept analysis of interdisciplinary collaboration.

2.6.1 Sharing

The first, and most common theme of concepts related to collaboration appearing in all the conceptualisations and models is the importance of sharing. At a practice level this concerns the ways different professionals share data, responsibilities, goals and decision-making. The importance of sharing goals is commonly named in ICP models, though it is noted the goals must be clearly stated and this sharing is only possible in contexts of dynamic communication amongst collaborators (Karam et al., 2018). The sharing of goals is also associated with the establishment of consensus where collaborators have established "an implicit understanding of how team members should work together" (Karam et al., 2018, p.77).

D'Amour et al. (2005) note another feature of sharing can be practitioners sharing their health care philosophies and perspectives so as to contribute to a relationship of mutual respect and trust. The importance of sharing in the establishment of trust is also identified by Orchard et al. (2005) who notes a trusting relationship is evident when there is a sharing of care, shared decision-making, sharing of responsibility, and a sharing of power. With regard to this latter point of sharing power, other authors also see strong connections between this and the establishment of trust. Karam et al. (2018) identified a strong intersection between trust, respect, mutual acquaintanceship and power. They argue that the central role of trust is highlighted when examining its opposite distrust. Distrust undermines interprofessional collaborative practice in the following five ways: doubting the motivations of others; feeling threatened by the involvement of others; exacerbating the differences in philosophies and scopes of practice; reinforcing the negative images of the profession of the other; fuelling a lack of confidence in the skills of the other professional (Karam et al., 2018).

2.6.2 Partnership

The notion of partnership was the second most commonly articulated component of collaborative working identified in the analysis of D'Amour et al. (2005). They describe

partnership as a collegial-like relationship between two or more actors participating in a collaborative undertaking that is authentic and constructive. Partnership describes a relationship which requires open and honest communication, as well as mutual trust and respect enabling the partners to pursue a set of common goals, or work towards specific outcomes. “Each partner must also be aware of and value the contributions and perspectives of the other professionals” (D'Amour et al., 2005, p.119).

The different frameworks/models identify a range of different partners to the collaborative practice. D’Amour et al. (2008) argue that different partners will hold “a variety of different types of allegiance: to the clientele, to the profession, to the organization and to private interests” (p.5). The client-centred nature of this partnership is also evident in the conceptual framework of Orchard et al. (2005) who describe ICP as: “a partnership between a team of health professionals and a patient in a participatory, collaborative and coordinated approach to share decision-making around health issues as the means to achieving improved health outcomes of patients” (p.9).

Patient-centredness features in other models of interprofessional collaborative practice also. Karam et al. (2018) note the importance of the patient and their family is often visible in models through indicators like care quality, safety standards and involving them in decision making about care. Of particular importance, Karam et al. (2018) argue, are the times when health professionals who are collaborating also work to maintain the presence of patients and their families as fellow active collaborators in this care.

2.6.3 Interdependence

Collaboration also requires that professionals be interdependent rather than autonomous. This is the third common theme across the frameworks identified by D’Amour et al. (2005) and was reinforced as significant by Karam (2018). Role clarification of the different collaborators is key to the development of this interdependence. Bronstein (2003), for example, argues that for practitioners to work interdependently they need to be clearly able to distinguish between their own role and the roles of others. To develop interdependence, Bronstein (2003) identifies the importance of “formal and informal time spent together, oral and written communication among professional colleagues, and respect for colleagues’ professional opinions and input” (p.299). Through these mechanisms, Ellingson (2002) argues, interdependency provides a platform where collaborators can

"focus on problem solving and opportunity finding, rather than on status and disciplinary boundaries" (p.13).

D'Amour et al. (2005) argue that as professionals develop ways to operate interdependently, the contributions of individual practitioners become maximised and synergy emerges: "the output of the whole becomes much larger than the sum of inputs from each part" (p.119). Similar links are identified by Orchard et al. (2005) who explain "collaboration, a relationship of interdependence, requires recognition of complementary roles and a respect for each discipline's scope of knowledge and uniqueness of functions" (p.4). Thus it can be seen the authors agree there are strong connections between these interdependent relationships and processes of boundary blurring and role flexibility.

2.6.4 Power

The fourth theme common across the frameworks concerns power, particularly, the need for power sharing in interprofessional collaborative relationships. As explained by Orchard et al. (2005) "collaboration based on a relationship of interdependence, built on respect, trust and understanding of the unique and complementary perspectives of each profession cannot occur without resolution of this power imbalance" (p.5). Earlier in this chapter the significance of the power imbalance between the medical and other professions was named. However, the complex hierarchy of power imbalances goes beyond just the place of the medical professions in our health systems.

Orchard et al. (2005) define power imbalances as "the ability to exert pressure on another by virtue of formal or informal positions" (p.2). The breadth of power imbalances in the health system affect relationships between medical, nursing, and other clinical professions (including those commonly grouped into the category of allied health professions), as well as those people working in health care who are not currently seen as professionals, like health care assistants. Practitioners working in social service organisations also name the power imbalance between themselves and those working in health organisations. Much has also been written about the power imbalances between health care practitioners and people seeking health care (and their families). As succinctly noted by Ellingson (2002) this "power disparity can cause a great deal of resentment and impede successful collaboration effort" (p.15).

Karam et al. (2018) argue that there are strong relationships between trust and power, with distrust being reinforced by power imbalances between practitioners: "power struggles

give rise to negative attitudes and the inability from both sides, to relate to each other as equals" (Karam et al., 2018, p.77). The authors note that these power imbalances were often raised in relation to the dominance of medical professionals (physicians) over other actors including nurses and community pharmacists. The potential impacts of these power imbalances upon ICP has been an important consideration in the rationale adopting a critical hermeneutics approach which is outlined in Chapter Four.

2.7 An evolving process

The fifth theme identified in the frameworks is the nature of interprofessional collaborative practice to be conceived as an evolving process. D'Amour et al. (2008) argue that interprofessional collaborative processes are always developed with two purposes in mind, to serve client needs and to serve professional needs, and that these two purposes are inseparable and dynamic: "one cannot collaborate without having taken the time to develop a collective life, and there is no use in developing a collective life without having first established the need to collaborate in responding to identifiable patient needs" (p.127). To collaborate, therefore, requires practitioners to develop a range of interactive and interpersonal processes to ensure they can individually and collectively contribute to care.

This dynamic process in some models is articulated as a series of steps. For example, Orchard et al. (2005) argue that transforming barriers to interprofessional collaborative practice (collaborative interdisciplinary practice) into enablers requires a change process of four phases: sensitization, exploration, intervention, and evaluation. During this final phase of evaluation, Orchard et al. (2005) note that all the participants in the collaboration "assess the impact of their collaboration on patients' satisfaction with their participation" (p.9), that is, the evaluation requires reflective action on behalf of the collaborators. Further, Orchard et al. (2005) argue that progressing through these four phases of change enables role clarification, role valuing and power sharing amongst collaborators.

In some instances, in the frameworks analysed, these steps are named as reflection. For example, Bronstein (2003) names one of the five core components of her model, *reflection on process*, which she describes as "collaborators' attention to their process of working together. This includes collaborators thinking and talking about their working relationship and process and incorporating feedback to strengthen collaborative relationships and effectiveness" (p.302).

2.7.1 Environmental and structural factors

Collaboration takes place within cultural and organisational contexts which can influence ICP, positively or negatively. Although D'Amour et al. (2005) did not name the importance of the environment and structural context as one of their five dominant themes, their model of collaboration, developed several years later recognised the significance of these contexts (D'Amour et al., 2008). Two of the four dimensions in their structuration model of collaboration involve the organisational context of collaboration: *governance* – focusing on the leadership functions of the organisational context which support collaboration; and *formalization* – where the organisation's expectations and responsibilities of different collaborators are clarified and implemented within the organisation's systems (D'Amour et al., 2008).

Karam et al. (2005) and Orchard et al. (2005) similarly accord much weight to environmental and structural factors. Orchard et al. (2005) refer to these factors using the term *organisational structuralism* which they define as: "the administrative organization and decision-making processes adopted within an institution to achieve mandates given by authority levels" (p.4). Orchard et al. (2005) identify organizational structuralism as one of three potential barriers to interprofessional collaborative practice (along with power relationships and role socialization). They argue that health care organisations need to be less rigid and controlling and provide more supportive environments and resources to enable practitioners to practice interprofessional collaboration.

Karam et al. (2005) identified two main aspects of the environment which impact on interprofessional collaborative practice: the macro environment, which they name as "the broader cultural, political, social, and economic issues that frame collaboration" (p.78); and the structural and organizational environment which is made up of the characteristics of the health organisation. The significance of these two broad aspects to ICP is discussed more fully in in Chapter Six where the broader landscape of ICP, including economic, historical, professional and organisational contexts, is discussed.

2.8 Interprofessional collaborative practice competency frameworks

Over the past 20 years, further conceptualisation of ICP has occurred through the development of ICP competency frameworks. Competencies are statements that describe knowledge, skills, abilities, and other characteristics that are established as essential for effective performance within certain roles (Campion et al., 2011). In the 1990s and early

2000s the desire to define competencies began to have significant impacts on both educators of health professionals and health professional bodies responsible for accrediting or re-certifying members of their organisations.

This competency movement intersected with other reforms in the education of health professions particularly those focused on health systems quality and patient safety. For example, the IOM (2001) published a key document which recommended that an interdisciplinary summit be held to address concerns of quality and safety. The report from this summit proposed a set of five core competencies that it recommended all practitioners required, regardless of their profession, to meet the future health system needs. The second of these five core competencies is focused on interprofessional collaborative practice and reads: "Work in interdisciplinary teams – cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable" (IOM, 2003, p.4)

Over the decade following the release of the IOM competency statements, organisations across the world responsible for the education and certification/accreditation of practitioners working in the health sector paid increasing attention to the development of competency frameworks. This work was supported by a range of national and international organisations like WHO:

> A collaborative practice-ready health worker is someone who has learned how to work in an interprofessional team and is competent to do so… After almost 50 years of enquiry, the WHO and its partners acknowledge that there is sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice. (2010, p.7)

A number of frameworks were developed to support this enablement of ICP with the following four receiving particular attention in the literature:

- Interprofessional Capabilities Framework by the Combined Universities Interprofessional Learning Unit (CUILU, 2004, revised 2009) – United Kingdom
- National Interprofessional Competency Framework by the Canadian Interprofessional Health Collaborative Working Group (CIHC, 2010) – Canada
- Interprofessional Capabilities Framework by Curtin University (2011) – Australia
- Core Competencies for Interprofessional Collaborative Practice by the Interprofessional Education Collaborative (IPEC, 2016) – USA

The competency frameworks are significant to this doctoral research for three main reasons: The authors of these frameworks all carried out significant reviews of literature on ICP to inform the development of the frameworks; The frameworks provide a distillation of the practice-based thinking of various professional bodies about interprofessional collaborative practice in four different countries; The frameworks represent what interprofessional competencies the educators of health care professionals believe are essential for the workforce of the future (e.g. IPEC's mission is "to ensure that new and current health professionals are proficient in the competencies essential for patient-centred, community and population-oriented, interprofessional, collaborative practice" (Interprofessional Education Collaborative, 2016, p.18).

2.8.1 An overview of the four competency frameworks

CIULU's Interprofessional Capability Framework was originally published in 2004. It was developed as a part of a three-year project funded by the Department of Health in the UK. The framework describes the learning outcomes that undergraduate health care students require in order to become capable interprofessional workers. Walsh, Gordon, Marshall, Wilson and Hunt (2005) explain the framework was developed using grounded theory to analyse the curriculum statements of undergraduate programmes of medicine, dentistry, nursing, midwifery and social work (p.233).

The 2004 framework was revised and updated in 2009. A mini-guide to this revised framework was produced in 2010 by the Interprofessional Education Team, Faculty of Health and Wellbeing, Sheffield Hallam University – one of the original collaborating universities on the project. The framework includes sixteen capabilities, at three different levels of achievement. The capabilities are organised into four domains: ethical practice; knowledge in practice; interprofessional working; and reflection.

The CIHC National Interprofessional Competency Framework was developed with the support of funds from Health Canada for the purpose of creating a Canada-wide competency framework for interprofessional collaboration. They began their work by analysing eight interprofessional collaborative practice competency frameworks which had been developed by different professional groups and education providers in Canada during the late 2000s. They then carried out a review of the associated literature. These two processes were used to develop the framework.

The Interprofessional Education Collaborative (IPEC) was formed in 2009 by a group of profession specific educational organisations in the United States with the purpose of developing core competencies for interprofessional collaborative practice. The six founding organisations represented the professions of dentistry, nursing, medicine, osteopathic medicine, pharmacy and public health. The core competencies were developed at a general level to enable alignment between the competencies and the expectations of individual professions and institutions. The original competencies were published in 2011. Over the following five years a number of developments led to further member organisations joining IPEC and a review of the original competencies. The reviewed competencies were published in 2016.

The 2013 Interprofessional Capability Framework was developed by Curtin University and built upon the two frameworks that were most commonly cited in SCOPUS at that time: The Interprofessional Capability Framework of CUILU and the National Interprofessional Competency Framework of the CIHC (Brewer & Jones, 2013). The authors combined their analysis of these two frameworks with a literature review to develop their own framework which they argue better intersects with the diverse curricula of the 23 disciplines within their health science faculty.

The Curtin University Interprofessional Capability Framework is organised around three core elements (client/family/community centred service/care; client safety and quality; and collaborative practice) and five capabilities (communication, team function, role clarification, conflict resolution and reflection). The Curtin University framework has maintained the strong focus on reflection that is visible in the CIULU framework and identifies reflection as one of their five capabilities.

2.8.2 Intersections between the competencies/capabilities in the four frameworks

An analysis of the domains in these four frameworks serves to demonstrate both commonalities and differences in understanding of interprofessional collaborative practice. The frameworks each identify between four and six domains of competencies/capabilities. All four frameworks have three domains with common topics: communication, team functioning, and role clarification. Two of the frameworks also include domains of reflection and conflict resolution. Two remaining domains are unique to the CIHC framework and do not have clear domain equivalents across other frameworks: These are

collaborative leadership and patient/client-centred care. However, these topics are mostly still visible in the competencies within the domains of the other frameworks.

Though there is no reference to leadership in any part of the CIULU framework, it was introduced in the later Curtin and IPEC frameworks – though it is not named as a domain/group of competencies. In the IPEC framework leadership is associated with the competency Teams and Teamwork where one sub-competency states: "Apply leadership practices that support collaborative practice and team effectiveness" (p.14). Similarly, there is a connection to leadership in the Curtin framework within the competency Collaborative Practice, where one of the level descriptors states: "Facilitates effective interprofessional team interactions and provides leadership when appropriate (p.8).

Table 3

Intersections between competency/capability domains in the four frameworks

Interprofessional Capabilities Framework (CUILU, 2009 revision) – UK	**National Interprofessional Competency Framework (CIHC, 2010) – Canada**	**Interprofessional Capabilities Framework (Curtin University, 2011) – Australia**	**Core Competencies for Interprofessional Collaborative Practice (IPEC, 2016 revision) – USA**
Collaborative working[4]	Interprofessional communication	Communication	Interprofessional communication
Organisational competence[5]	Role clarification	Role clarification	Roles/responsibilities
	Team functioning	Team function	Teams & teamwork
Cultural awareness and ethical practice			Values/ethics
	Interprofessional conflict resolution	Conflict Resolution	
Reflection		Reflection	
	Collaborative leadership		
	Patient-/client-centred care		

Though the CIHC framework is the only one to name the significance of a patient/client focus as a domain, the Curtin framework also accords much importance to the patient/client, whom they refer to as the client. Within the Curtin framework three core

[4] Though the title does not use the term communication, the descriptor of the capability Collaborative Working clearly identifies communication: "emphasises the importance of the collaborative worker utilising interpersonal skills to promote effective communication leading to shared decision making regarding the setting and achieving of mutually agreed goals" (p.6).

[5] Though the title does not use the terms role, team, or teamwork, the importance of role boundaries and team function is emphasised within the descriptors of this capability of Organisational Competence: there are five statements that refer to role boundaries and six statements that refer to team function.

elements are identified which are named as underpinning the five domains of the capabilities with the centrality of the client clearly visible in two of these: client centred service; client safety and quality; collaborative practice. The client is described in these statements of the core elements:

> The client is valued as an important partner in planning and implementing services/care. Service providers seek out and integrate the client's input into services. Service providers promote the participation and autonomy of clients to ensure that they are involved in decision making and exercise choice. (p.6)

Neither the IPEC nor the CIULU frameworks identify such a central focus of the patient/client. Nevertheless, their importance is still visible within both frameworks. IPEC utilises the term patient-centred care. The importance of patient-centred care is visible in the mission statement of IPEC: "to ensure that new and current health professionals are proficient in the competencies essential for patient-centered, community and population oriented, interprofessional, collaborative practice" (p.18). They also refer to the importance of patient-centred care in their definition of interprofessional teamwork, defined as: "The levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care" (p.8). There are two further links to patient-centred care in two of the descriptors of sub-competencies within both the Interpersonal Communication, and Team and Teamwork competency domains.

The CIULU framework uses the phrases *person centred* and *person focused* instead of the term patient/client. There are fewer statements than IPEC to identify the significance of this focus in the CIULU framework. Nevertheless, within the domain Cultural Awareness and Ethical Practice the CIULU framework describes the importance of the collaborative worker contributing "to the delivery of culturally appropriate and person centred services" (p.18).

In Table 3 there are some clear patterns of commonality in the domains (or clusters) of competencies. However, examination of the competency statements within these domains can make comparison of the competency frameworks problematic. This difficulty led to the research project of Suter et al. (2009) who aimed to identify which collaborative practice competencies were considered key by professionals directly providing health services. Their research identified two competencies that were seen as the most significant by practitioners: understanding and appreciating the roles and responsibilities of other professionals; and communicating effectively with other professionals. A further point argued by Suter et al.

(2009) is that reflection, although important for ICP, is not a competency in itself but rather a tool to enable professionals to embrace new practices (Suter et al., 2009, p.48).

2.9 Conclusion

In the midst of what Day (2013) refers to as the 'terminological quagmire', where a multiplicity of terms with endless permutations confound meaning, it was initially difficult to hone in upon which term most aptly describes my area of focus and attention. More than 25 years ago Leathard (1990) argued "What everyone is really talking about is simply learning and working together" (p.1776). The simplicity of this focus on learning and working together has consolidated my decision to use the phrase *interprofessional collaborative practice* to define the focus of my attention. The use of the term interprofessional is common in Aotearoa/New Zealand and weaves in the importance of the different practitioners involved in PHC. Slight variations of this phrase are commonly used in the literature and in competency frameworks. By utilising the terms collaboration and practice, the phrase picks up on Leathard's challenge to embody a spirit of learning and working together.

Though the term interprofessional is inclusive of the different health and social service professions involved in PHC, I am conscious that this term does not readily acknowledge the important roles of the non-regulated workforce and the roles of patients/clients and their care-givers/family. The non-regulated workforce is increasingly being named as key to the provision of services within PHC in New Zealand and I will not exclude these people from my attention. Similarly, I will remain attentive to the place of clients/patients as well as their care-givers and families as I proceed with this study, though these will not be the main focus of my research as this would widen the scope of the study too far. Instead, I will particularly attend to the nature of collaborative practices in the working lives of practitioners in PHC contexts in Aotearoa/New Zealand.

Much of the literature on collaborative practice focuses on how to set up teams, how to organise team working, and how to manage these teams (Croker et al., 2009; D'Amour et al., 2005). There is much less literature exploring the processes of how people actually work collaboratively with each other. This research addresses a key aspect of this gap by exploring how practitioners in PHC contexts in New Zealand understand their ways of working collaboratively with each other. I am interested in how practitioners describe what they do when they say they are collaborating with other professionals, who this collaboration

involves, and what shapes or influences these practices. I have shown that a significant factor in interprofessional collaborative practice is a consideration of power. This study will incorporate an analysis of power through the application of a critical hermeneutics analysis to the under-explored meanings associated with interprofessional collaborative practice.

Analysis of the complexity involved in conceptualising ICP, as discussed in the literature, supports the goal of this research to explore what understanding of ICP is held by health care practitioners in Aotearoa/New Zealand. Further, this exploration of the conceptualisation of ICP identifies a place for critical reflection upon such matters as professional identity, roles and relationships of power. Key aspects of literature discussing this place of reflection with regard to ICP in PHC are the subject of the following chapter.

Chapter 3 – Reflective practice

3.1 Introduction

Connections between RP and ICP are visible in the literature of ICP discussed in the previous chapter. For example, several models of ICP identify the place of reflection in contributing to an evaluation of ICP processes (Bronstein, 2003; Orchard et al., 2005). However, as discussed in this chapter, the conceptualisation of RP, in a similar way to ICP, has a long history of being complex:

> Despite all that has been written about reflection it is difficult to be precise about the nature of the process. It is so integral to every aspect of learning that in some way it touches most of the processes of the mind. (Boud, Keogh, & Walker, 1985, p.21)

More than 30 years later this lack of precision continues to be one of the key challenges of explorations of RP. Authors have noted that widely varying understandings of the term have led to difficulties in comparisons of research studies as well as difficulties in clarifying expectations of professionals with regard to their RP (Asselin, Schwartz-Barcott, & Osterman, 2013; Fook, 2010; Mann, Gordon, & MacLeod, 2009; Thompson & Pascal, 2012).

Nevertheless, internationally and nationally RP continues to be identified as an important component of initial, and continuing, education and professional development in the health professions (Fook & Gardner, 2013; Gustafsson & Fagerberg, 2004; Mann et al., 2009). In these contexts RP is commonly cited as "returning to an experience to examine it, deliberately intending that what is learned may be a guide in future situations, and incorporating it into one's existing knowledge" (Mann et al., 2009).

Review of the literature considered what theories and theorists of RP informed the practices of these professions in PHC. Three discourses of RP were identified in the literature. In this chapter these three discourses are used to critically reflect on the nature of RP in PHC. In Section 3.2, which follows, the main theories and theorists of RP that have influenced the professions are discussed. Then in Section 3.3 the ways professionals in PHC have engaged with these concepts of RP are explored.

3.1.1 Literature search strategy

CINAHL Plus, PubMed and Scopus databases were searched using the following keywords: reflection; reflective practice; primary care; PHC, nursing, pharmacy and medicine. The focus on these terms was informed by the systematic literature review on RP in health profession education carried out by Mann et al. (2009). Literature was supplemented through hand searches and reviews of the bibliographies of identified articles. Only literature related to PHC was retained, with particular attention being paid to the professions of general practice doctors, nurses, and pharmacists.

3.2 Main theories and theorists of reflective practice

Seminal work on reflection in the professions was produced in the 1970s and 1980s by Chris Argyris, David Boud, Rosemary Keogh, David Kolb, Jack Mezirow, Donald Schön and David Walker. Though most of these authors continued to write on reflection for the professions in the following decades, their early works continue to be commonly cited in literature on RP: (Argyris & Schön, 1974; Boud, Keogh, & Walker, 1985; Kolb, 1984; Mezirow, 1994; Mezirow, 1981; Schön, 1983; 1987). In particular, the work of Boud, Kolb, Mezirow and Schön feature significantly in literature on RP in PHC. Key concepts of their work, therefore, are described here before discussing the ways that the different professions draw upon their RP concepts.

These early theorists all acknowledge the influences of other twentieth century scholars, particularly the work of the renowned philosopher/educationalist John Dewey (1933) and his argument that education needs to prepare students to become reflective, autonomous, ethical beings who have the capacity to actively engage with knowledge. However, these early RP theorists suggest that Dewey placed too much emphasis on the rational, controlled thinking aspects of reflection and that more attention to other aspects was needed. For example: Boud, Keogh and Walker (1985) note they "give much greater emphasis [than Dewey] to the affective aspects of learning, the opportunities these provide for enhancing reflection and the barriers which these pose to it" (p.21).

3.2.1 David Boud

David Boud has been an important contributor to the field of RP for more than 30 years. It is worth noting that in their oft-cited text Boud et al. (1985) did not use the term RP, but used the noun *reflection* and the phrases *reflective process* or *reflection in the learning*

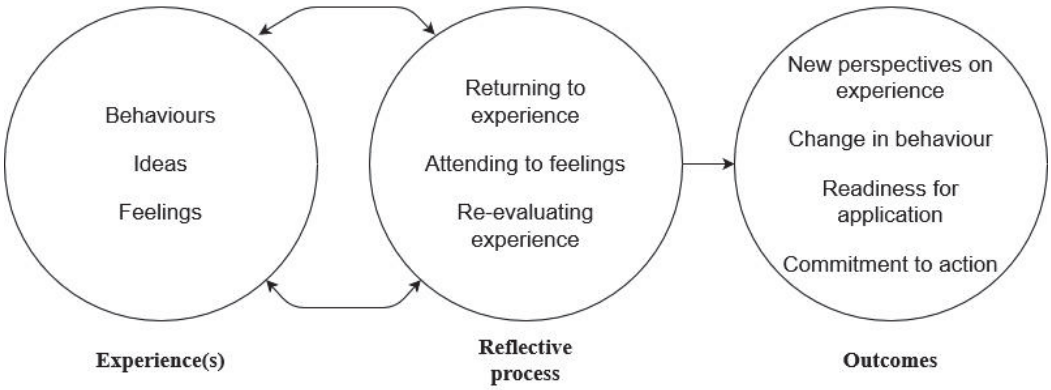
process. Nevertheless, the following definition of their process of reflection is commonly attached to the term RP in later literature:

> Reflection in the context of learning is a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation. (Boud et al., 1985, p.19)

Boud, along with colleagues Keogh and Walker, developed a model of *reflection in the learning process* which continues to be commonly cited in explorations of RP in the health professions. The model comprises three main areas: experience(s); reflective processes; and outcomes (see Figure 1). The authors argue that reflective processes are essential as it is rarely profitable to move straight from having an experience to re-evaluating the experience: "we may find ourselves operating on false assumptions or reflecting on information which we have not comprehended sufficiently" (Boud et al., 1985, p.30).

Figure 1

Reflection in the learning process (Boud et al., 1985)



When they refer to experience, the authors note the different nature of experience, which may be a singular, isolated event or a collection of experiences over time and incorporates: "the totality of experiences of learners, the behaviour in which they have engaged, the ideas of which learners are aware and the feelings which they have experienced" (Boud et al., 1985, p.20). They explain that the motivation for reflection following experience may be prompted by a positive experience, for example a sense of having achieved a difficult task; or be prompted by dissatisfaction and discomfort, for example "a loss of confidence in or disillusionment with one's existing situation" (Boud et al., 1985, p.19).

The *reflective processes* component of their model has three stages: Stage 1 is a returning to the experience; Stage 2 is attending to feelings; and Stage 3 is re-evaluating the experience. At Stage 1 a person focuses on carefully recollecting the events (they suggest either on paper or with others) with the purpose of considering details of the experience, their responses to the experience, and the wider context of the experience more carefully: "As we witness the events again they become available for us to reconsider and examine afresh; we realize what we were feeling and what responses prompted us to act as we did" (Boud et al., 1985, p.27). Careful attention to this stage is essential in the model and they note "often false perceptions can be detected by recollection alone" (Boud et al., 1985, p.28). The authors suggest keeping the description of the experience as free as possible from judgement and evaluation as these "tend to cloud our recollections and may blind us to some of the features which we may need to reassess" (Boud et al., 1985, p.28).

The process of reflection at Stage 2 is focused upon feelings. This requires us to "work with our emotional responses, find ways of setting them aside, or if they are positive ones, retaining and enhancing them" (Boud et al., 1985, p.29). Boud et al. (1985) argue that our emotions and feelings can be both a source of learning, and a barrier to learning.

> Sometimes in reflection we are not able to recollect events clearly, or we may be so rooted in one perspective or fixed on a given interpretation, that we give up reflection believing that we have reached an understanding of the experience. Commonly what has happened is that an affective barrier has been raised which has temporarily disabled us. (p.29)

It is intended that this attention to feelings is an essential preparation before the next stage of re-evaluating their experience.

The authors identify four important aspects of this process of re-evaluation of the experience through the processes of reflection: association; integration; validation; appropriation. They define association as "the connecting of the ideas and feelings which are part of the original experience and those which have occurred during reflection with existing knowledge and attitudes" (Boud et al., 1985, p.31). They suggest there are a range of techniques to accomplish this which can draw on psychoanalytic theory like brainstorming, writing, drawing or talking to others.

To ensure that associations become meaningful, Boud et al. (1985) argue they must be integrated into a "new whole" by "seeking the nature of relationships that have been observed through association" and "drawing conclusions and arriving at insights" (p.32).

They suggest that visual processes of charting and mapping relationships from the association phase can assist in clarifying these insights. However, they also note that some non-visual techniques like explorations of "analogies, similes, and metaphors" can also be helpful.

In the third aspect of evaluation, *validation*, the authors explain "we are testing for internal consistency between our new appreciations and our existing knowledge and beliefs, for consistency between these and parallel data from others and trying out our new perceptions in new situations" (Boud et al., 1985, pp.32-33). A useful technique they propose is to rehearse enacting this new learning. This might entail internally visualising what might happen if this learning is put into practice; or it could involve others through a role-playing or simulation activity.

Finally, the authors argue that some new knowledge requires a further step of evaluation, that of appropriation. Appropriated knowledge is more strongly connected to our sense of identity and our values, thus, they argue "it is less amenable to change than other knowledge which we accept and work with but do not make our own to the same degree" (Boud et al., 1985, p.34). The authors explain that not all knowledge requires appropriation and that the first three processes of evaluation may be sufficient (appropriation; integration; validation) to lead to outcomes and action.

In the final stage of the model, Boud et al. (1985) explain that the outcomes of the reflective processes are varied:

> [They] may include a new way of doing something, the clarification of an issue, the development of a skill or the resolution of a problem. A new cognitive map may emerge, or a new set of ideas may be identified. The changes may be quite small or they may be large. They could involve the development of new perspectives on experience or changes in behaviour. (p.34)

Over the decades Boud has re-examined his earlier work on reflection and RP to consider its relevance for the present and future (Boud, Cressey, & Docherty, 2006; Boud, 2010). He concludes that reflection and RP continue to be relevant for the professions and that the original work from the 1980s continues to hold ideas that are important for professionals to consider. However, he argues that there are some aspects of reflection that require rehabilitating and some areas that require further development (Boud, 2010). I explore aspects of these in the final section of this chapter.

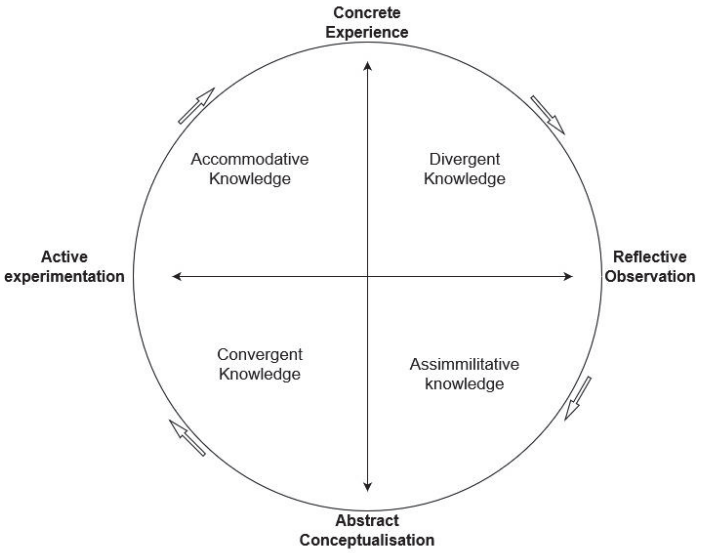
3.2.2 David Kolb

David Kolb is an educational theorist who writes on experiential learning and professional development. Kolb (1984) proposes that learning is a fundamental aspect of human development and influences the personal development of people throughout their lifespan. Kolb (1954) describes his *experiential learning theory* (ELT) as: "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience" (p.41). Hickcox (1991) argues that Kolb integrated the work of John Dewey, Kurt Lewin, and Jean Piaget to formulate his theory.

The key area of Kolb's ELT that is drawn upon in the RP literature is his four-stage cycle of learning involving four adaptive learning modes: concrete experience, reflective observation, abstract conceptualisation and active experimentation. In Kolb's conceptualisation of this cycle of learning he explores "two dialectically opposed adaptive orientations" (Kolb, 1984, p.41) to learning. The first of these is the *abstract/concrete dialectic* which represents how people experience or perceive the world and their experiences in it. In Figure 2 this is represented by the vertical axis. The second of the adaptive orientations identified by Kolb is the *active/reflective dialectic* representing the different ways that experience is grasped or approached by the learner/professional. This is represented by the horizontal axis in Figure 2.

Figure 2

Kolb's Experiential Learning Theory



The main application of Kolb's ELT in the health professions utilises the idea of progressing through the four different ways of grasping and transforming experience as a way of learning from experience. As explained by Kolb, Boyatzis and Mainemelis (2000):

> Immediate or concrete experiences are the basis for observations and reflections. These reflections are assimilated and distilled into abstract concepts from which new implications for action can be drawn. These implications can be actively tested and serve as guides in creating new experiences. (p.3)

3.2.3 Jack Mezirow

Jack Mezirow is credited with being one of the most influential thinkers in adult education of the past century (Marsick & Finger, 2001). Whilst developing his critical theory of adult learning and education in the 1970s and 1980s Mezirow used Habermas' work on domains of learning to develop his own concept of *perspective transformation* (Mezirow, 1981) which became a key component of Mezirow's later theory of transformative learning (1990; 1991; 2000; 2009). He is recognised as a significant theorist in the literature of RP and challenged some of the ideas of Kolb arguing that reflection and action should not polarised in the ways that Kolb discusses them (Mezirow, 1990).

Mezirow (1990) makes a distinction between thoughtful action and reflective action noting that thoughtful action is "simply reflexively drawing on what one already knows in order to act" (p.4). Whereas reflective action occurs in the context of problem solving when

there is a need to move past the "situational, knowledge and emotional constraints" encountered (Mezirow, 1994, p.226). In these situations, Mezirow (1990) argues reflection involves a pause in action to re-assess "What am I doing wrong?" (p.4). He identifies that this reflective action can take one of three forms: reflecting on content (what we perceive, think, feel, and act); reflecting on process (how we perform the functions of perceiving); and reflecting on the premises which underpin the problems we are making sense of in our learning experiences (Mezirow, 1990).

It is the last of these, premise reflection (also referred to by Mezirow as critical premise reflection), which he claims is the least common. Yet, this critical reflection enables us to examine the presuppositions which underly our knowledge of the world through asking questions such as, "why does it matter that I attend to this problem, does it matter that I chose this problem, is there an alternative?" (Mezirow, 1991, p.31). Other forms of reflection are important, but it is only this critical premise reflection which enables what Mezirow refers to as a transformation of our meaning perspectives. In other words, this critical reflection leads us to undertake a critical assessment of our unexamined assumptions or beliefs that are influencing our actions. Mezirow argues this kind of critical reflection is typically triggered by encountering a disorienting dilemma where our tried and tested ways of acting are no longer sufficient to make sense of the situation we find ourselves in.

Mezirow (1994) has demonstrated that this critical premise reflection typically goes through the following phases:

1. A disorienting dilemma
2. Self-examination with feelings of guilt or shame, sometimes turning to religion for support
3. A critical assessment of assumptions
4. Recognition that one's discontent and the process of transformation are shared and others have negotiated a similar change
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquiring knowledge and skills for implementing one's plans
8. Provisionally trying out new roles
9. Renegotiating relationships and negotiating new relationships

10. Building competence and self-confidence in new roles and relationships
11. A reintegration into one's life on the basis of conditions dictated by one's new perspective. (p.224)

3.2.4 Donald Schön

Donald Schön is credited with developing the term the reflective practitioner, as it applies to the professional and their practice (1983; 1987). His work is drawn upon extensively in the health professional literature. Schön argued that technical rationality had taken over the training and education of professionals to their detriment. He proposed that the histories of the professions had indicated we have drawn too heavily upon empirical, technical knowledge in our efforts to prepare professionals for practice, and that other forms of knowing had become under-valued. Schön (1987) argued that the professional also draws upon knowledge that can be described as artistry which he defined as "the competence by which practitioners actually handle indeterminate zones of practice" (p.22). He contends that in fact artistry is "not inherently mysterious; it is rigorous in its own terms" (p.13). He indicated that careful examination of highly competent professionals would enable us to identify their artistry. Two primary concepts in this regard are *knowing-in-action* and *reflecting-in-action*.

Schön used the term knowing-in-action (and its corollary reflecting-in-action) to define some of the important differences in the way our knowing and acting can lead to learning about our professional behaviour and thinking. Schön (1987) defines knowing-in-action as "the sorts of know-how we reveal in our intelligent action – public observable, physical performances like riding a bicycle and private operations like instant analysis of a balance sheet" (p.25). The key aspect of this concept for Schön is that this kind of knowing occurs in the midst of action. We are not necessarily able to verbally describe the totality of our knowing. Instead, we need to construct descriptions of parts of the knowing by referring "to sequences of operations and procedures we execute", or describing the "clues we observe and rules we follow" (Schön, 1987, p.25).

These descriptions of knowing-in-action Schön refers to as knowledge-in-action. They are constructions that we use to describe our knowing-in-action. Schön argues that these constructions do not adequately capture the tacit, spontaneous, dynamic activity (or artistry) of the professional's actions. If we base our professional training on these constructions of knowledge-in-action, Schön argues, then we do not allow ourselves the opportunity to explore the more dynamic aspects of our actions and thinking.

Schön notes that sometimes our spontaneous knowing-in-action is insufficient for an unexpected or new situation. In this instance, we either brush aside this unusual instance of experience and do not engage with its uniqueness, or we respond to it by some form of reflection. Schön proposes that there are two kinds of reflection that we can choose. Firstly, we can reflect on the action by thinking back to what we have just done (knowing in action) which may have contributed to this unique situation. This reflection on action can occur either after the action or after part of the action is complete. It is not, however, connected directly to the action in the way that the second kind of reflection, reflecting-in-action, happens.

When the professional undergoes a process of reflecting-in-action they consider the situation that led to the unexpected outcome of their knowing-in-action in the midst of the action itself. This results in a meta-cognitive activity where the professional thinks back upon their own thinking around the action and its unintended consequence whilst the thinking and acting are occurring. This reflection, according to Schön, gives rise to some critical thinking leading to on-the-spot changes or experimental actions. Schön proposed that it is this kind of reflecting-in-action which characterises the reflective practitioner. The reflective practitioner is able to engage in continuous, reflexive changes to their practice because of their ability to reflect in the midst of action and to artistically adjust the kinds of thinking and knowing that they are participating in.

Much of the literature examining RP that draws on Schön's work does not progress beyond an exploration of these key concepts. Schön also writes, however, about broader aspects of the place of professional knowledge in society. Schön draws on the work of Mannheim to explore the idea of frame analysis which he defines as "the study of the ways in which practitioners frame problems and roles" (p.309). For Schön, the relevance of frame analysis to professional thinking is that when a professional is able to become aware of their framing of problems and roles then they are able to consider possible alternative ways of framing their reality.

Schön advocates the importance of critically exploring how our dominant frames of practice emerge within particular social environments. Using Mannheim's work, Schön explains how our view of reality evolves out of the "concrete situations of particular social groups" whose interests are served by this reality (p.312). He outlines how the institutional context of the professional's practice is important since "our knowing-in-action is embedded in the socially and institutionally constructed context shared by a community of

practitioners" (Schön, 1987, p.33). This consideration of the social context of professional practice is an important part of a critical perspective on RP, which I discuss further below in the section on RP as critical reflection.

Table 4

An overview of the four early theorists

	Boud et al. (1985)	**Kolb (1984)**	**Mezirow (1981, 1991, 1994)**	**Schön (1983, 1987)**
What is being reflected upon?	totality of experiences of learners: • behaviour in which they have engaged • ideas of which they're aware • feelings they've experienced	Concrete experience	Content (what we perceive, think feel, and act) Process (how we perform the functions of perceiving) Premises which underpin what we're making sense of	Tacit norms and appreciations underlying judgements Strategies & theories implicit in behaviour Feelings for a situation which shaped action Framing of a problem & one's role within institutional context
Initiation of reflection	A dissatisfaction leading to a reconsideration An experience of successfully surmounting an obstacle	Immediate or concrete experiences	A disorienting dilemma A need to move past "situational, knowledge and emotional constraints" (1994, p.226)	A gap between what is known and the demands of real-world practice Surprises (pleasing or unwanted) from intuitive responses to practice
Reflective process	1. *Returning to experience* 2. *Attending to feelings* 3. *Re-evaluation of experience* 4. *Outcome/Resolution*	1. *concrete experience* 2. *reflective observation* 3. *abstract conceptualisation* 4. *active experimentation*	11 phases including: self-examination, critical assessment of assumptions, planning a course of action, building competence and self-confidence, and re-integration into one's life	*Reflection-on-action:* spontaneous knowing-in-action is insufficient for an unexpected/new situation *Reflection-in-action*: (a meta-cognitive activity) artistically adjusting thinking & knowing in the midst of action
Learning and the learner /professional	Past experiences: affect perceptions of world and new experiences Emotions: a source of learning; a barrier to learning Reflection enables drawing conclusions and arriving at insights.	Knowledge as the transaction between social knowledge and personal knowledge Learning is the process: knowledge is created through transformation of experience	"We have a strong urgent need to understand the meaning of our experience…we strive toward viewpoints which are more functional, more inclusive, discriminating and integrative of our experience" (1994, p.223)	Engagement in artistry: "the competence by which practitioners actually handle indeterminate zones of practice" (Schön, 1987, p.22).

3.3 Three primary discourses of reflective practice in the primary health care literature

A review of RP in the PHC literature shows there are three primary discourses of RP that dominate: RP as reviewing, re-evaluating, and consolidating thinking in relation to practice; RP as making sense of the unfamiliar, particularly drawing on notions of artistry, practice wisdom and phronesis; RP as critical practice focused on uncovering and making sense of dominant assumptions about practice. In the following sections each of these discourses is discussed drawing upon incidences of these discourses in PHC literature.

3.3.1 Reflective practice as explorations of thinking and reasoning

The importance of reflection to practice in the health professions often centres upon thinking/reasoning, resulting in use of the terms *reflective thinking* or *reflective reasoning* alongside the term RP. One key place this importance is visible is in the competency frameworks published by the professional bodies of health professionals. In PHC in Aotearoa/New Zealand the competency frameworks of the following professional bodies are of particular relevance: The Medical Council of New Zealand (2018), the Nursing Council of New Zealand (2012), the Pharmacy Council of New Zealand (2021), the Podiatrists Board of New Zealand (2021), and the Social Workers Registration Board (2021).

Analysis of the frameworks shows these professional bodies all identify expectations of RP in their members' professional activities with a particular focus on reflective thinking and reasoning. As a part of routine re-accreditation/re-certification processes, members of these professional bodies are expected to provide summaries of evidence of their abilities to reflect in these ways. Some examples of excerpts from the documents of these professional bodies demonstrating these expectations are in Appendix A.

This discourse of reflection is especially dominant in the literature of medicine, where RP is associated with the development of the doctors' diagnostic reasoning, clinical reasoning and therapeutic reasoning (Mamede, 2005; Mamede & Schmidt, 2017). This focus upon reasoning is strongly intertwined with the genealogy of RP and is visible here in Dewey's (1933) exploration of reflection:

> Active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and further conclusions to which it leads… it includes a conscious and voluntary effort to establish belief upon a firm basis of evidence and rationality. (p.9)

This discourse of RP in PHC is associated with improving professional practice and commonly uses the language of clinical reasoning. For example, Plack and Greenberg (2005) writing about RP in medicine describe the ways that doctors explore "their own values, beliefs, attitudes and assumptions" to consider how these impact on their clinical reasoning (p.1548). This often entails encouraging the doctor to make the subconscious, conscious. For example, Maddocks (2018) examination of the place of RP in the training of New Zealand Defence Force medics who provide PHC to military personnel notes RP "helps formalise subconscious thoughts and actions to a more deliberate and systematic process to help inform future practice" (p.36). There are strong associations between this idea of clinical reasoning and the development of doctors' meta-cognitive reasoning where they are "critically thinking about their own professional activities, thereby analysing their own decisions and reasoning" (Mamede, 2005, p.327).

The development of a questioning mindset is strongly associated with developing the doctor's ability to draw upon evidence-based reasoning and focus on best-practice guidelines. For example, Maddocks explains that the New Zealand Defence Force medics are trained "to engage with extant and emerging literature early within their learning and to develop a 'best practice' mind-set providing evidenced based care for future patient encounters" (p.36).

In some instances in the literature this improvement of PHC via mechanisms of RP is framed as quality improvement of services. Vachon et al. (2015) argue that meaningful improvement in the management of LTCs in PHC "requires a coherent, integrated approach to quality improvement" (p.1). They argue that improvement of care results in changes to services through utilisation of "strategies such as feedback delivery, RP and action planning to facilitate recognition of gaps and service improvement needs" (Vachon et al., 2015, p.1).

3.3.2 Reflective practice as making sense of the unfamiliar

The second discourse of RP in literature of health professionals considers the place of RP in aiding the professional to move beyond habitual action when they encounter the unfamiliar. This idea can also be traced back to the work of Dewey which informed all the key theorists in the RP literature outlined earlier in this chapter. Dewey (1933) discussed reflection as a way "to transform a situation in which there is experienced obscurity, doubt, conflict, disturbance of some sort, into a situation that is clear, coherent, settled, harmonious" (pp. 100–101). The RP of Boud, Mezirow and Schon all discuss this

experience of the unfamiliar prompts RP (see Table 4 earlier in this chapter). Schon, for example, refers to the value of RP in assisting the practitioner when they find themselves in "the swampy lowlands, where situations are confusing messes incapable of technical solution and usually involve problems of greatest human concern" (Schön, 1983, p.42). This discourse of RP is visible in the literature of both medicine and nursing.

In medicine RP is commonly identified as processes of reflecting on complex, non-routine cases that are poorly defined (Bernabeo, Holmboe, Ross, Chesluk, & Ginsburg, 2012; Mamede & Schmidt, 2004; Wilson & Cunningham, 2013). Bernabeo et al. (2012) draw upon the work of Kolb, Mezirow and Schön and argue that RP is key to the development of professionalism in medical education, and in particular, the ability of professionals to respond to dilemmas in practice.

One aspect of responding to these dilemmas involves supporting doctors to make sense of their reactivity to certain patients: “Some patients make us feel unusually disturbed or behave untypically. Even unprofessionally” (Salinsky, 2018, p.10). Doctors’ participation in a particular kind of peer supervision group, called Balint groups can assist them with this reactivity. The structure of these groups follows a process established by psychoanalyst Michael Balint in London in the 1950s. Their focus is “to allow discussion of any topic that occupies a physician’s mind outside of his or her usual clinical encounters” (Roberts, 2012). The psychodynamic foundation of Balint groups means they typically focus on the relationships between the doctor and their patient, and in particular the place of emotions in these relationships. Salinsky (2018) explains that the Balint group provides the doctor with:

> The chance to develop a greater knowledge of ourselves including some of the lower depths where the shadow lurks. We may remember that Michael Balint’s stated aim was for his doctors to achieve nothing less than a change in personality. A limited change—but a considerable one.” (p.10)

In nursing, RP is considered to be an essential component of good nursing practice with the discourse of making sense of the unfamiliar being particularly evident. Processes of RP are routinely incorporated into nursing curricula and commonly feature in national professional nursing competency frameworks. For example, in Aotearoa/New Zealand reflection is named as one of the key competencies for registered nurses by the Nursing Council of New Zealand: “Competency 2.8 - Reflects upon, and evaluates with peers and experienced nurses, the effectiveness of nursing care” (p.21).

Utilising RP to develop an awareness of self in relation to practice, is particularly visible in the literature of nursing RP. One particular feature of this, is an expectation that nurses will pay attention to emotions and feelings in their work. This attention to feelings is visible in two models of RP which feature in nursing literature: *Gibbs' Reflective Cycle;* and Johns' *Model for Structured Reflection.* Both of these models are informed by the work of the early theorists in RP outlined earlier in this chapter. The models take the practitioner down a path of thinking back upon particular experiences/events and applying the model as a way to make sense of the experience and to inform future practice.

In Gibbs' Reflective Cycle the practitioner is invited, at one step in the cycle, to consider "What were your feelings and how did you react?". Bulman (2013) explains that as they have drawn on Gibbs model at Oxford Brookes University with their nursing and midwifery students, they have come to increasingly value the importance of this affective dimension (p.231). Consequently, in recent years they have added this evaluative question: "What was good and bad about the experience? (Evaluate your initial feelings and reactions in order to get to the heart of what really concerned you (positive or negative) about the experience)" (Bulman, 2013, p.233).

Similarly, Johns (2013) makes strong links to the affective domain of reflection in his model and weaves these links into the development of self and development of practice. The latest version of Johns' model has five phases: preparatory; descriptive; reflective; anticipatory; and insight. Each of these has a number of open questions to assist with making sense of practice experience. In the reflective phase there are nine questions for the practitioner to explore with the following three illustrating the significance of exploring feelings to make sense of the unfamiliar: "How were others feeling and why did they feel that way?; How was I feeling and what made me feel that way?; What assumptions govern my practice and what factors influence the way I feel, think and respond to the particular situation?" (p.38)

3.3.3 Reflective practice as critical reflection

Although the term critical reflection has been used alongside RP since the 1970s (particularly in the work of Mezirow) it has increasingly come to be used to define particular meanings of reflection that are argued to be unique and separate from RP. Dominant voices in the argument for utilisation of a different term to RP have been those of Jan Fook & Fiona Gardner (Fook, 2010; Fook & Gardner, 2013). At different times Fook has argued that

critical reflection is a cousin to RP, or a subset of RP. Fook defines critical reflection as: "the ability to understand the social dimensions and political functions of experience and meaning making, and the ability to apply this understanding in working in social contexts" (p.50). Fook and Gardner (2013) argue that critical reflection particularly draws on critical theory and an analysis of power, knowledge and reflexivity. Critical reflection embraces the importance of unearthing the assumptions in our thinking and actions, and confronting culturally embedded ideas. These critical ideas of reflection have been highly influential in discourses of RP within both social work and nursing over several decades but do not hold such a central place in the RP literature in medicine.

Fook utilises the work of Mezirow in her conceptualisation of critical reflection and similarly pays attention to the ways that the realms of the individual (thinking, perceiving and acting) and the social are linked. This is particularly visible in Mezirow's exploration of critical premises reflection which he says entails becoming critically aware of our background established and habitual ways of acting. Critical premises reflection, Mezirow argues involves questioning "the meaning perspectives with which we have made sense out of our encounters with the world, others, and ourselves" (p.32). Of note is that the work of Mezirow has focused particularly upon the field of adult education, whereas Fook has focused her work on critical reflection in the professions.

3.3.4 Intersections between reflective practice and ICP

Though there continues to be a substantial literature on the importance of RP in the health professions, this relevance has not been unchallenged. One significant challenge has been that RP has been overly focused on the introspective RP of the individual. Instead, it is argued, RP needs to be incorporated into how practitioners are increasingly expected to work with each other in teams (Bradbury, Frost, Kilminster, & Zukas, 2010; Fook, 2010; Ghaye, 2005; Ghaye, 2008; Greenwood, 1993).

There is little current research in PHC that focuses on the intersection between ICP and RP, though this intersection is visible in some places. For example, the examination of the contributions of continuing professional development activity of PHC interprofessional teams to the quality improvement of the organisation by Vachon et al. (2015) considered the place of RP in these processes. In spite of the dearth of material in PHC related to this intersection between ICP and RP, it was noted in Chapter Two that several models of ICP and frameworks of competencies in ICP signal the place for reflection and RP. For example,

in Bronstein's Model of Interprofessional Collaborative Practice, reflection on process is one of the five core components. Similarly, reflection appears as an important competency or set of competencies within the four commonly cited ICP competency frameworks explored in Chapter Two.

3.4 Conclusion

Professionals in PHC recognise the importance of RP to their work and there are commonalities in the concepts of RP that inform their understanding: reflecting upon experience(s), exploring assumptions, and learning from this process. However, an analysis of the discourses of RP discerned in the literature demonstrates some quite different emphases on what is being reflected upon, and what kinds of assumptions are being explored through the reflective process. Variations in RP across the PHC professions are particularly tied to the different emphases placed upon different aspects of thinking, feeling, context, self, and power. This makes comparison of the different ways that professionals think about RP difficult.

There are important considerations about the relationships between RP and ICP which were identified in the previous chapter. However, the relationships between these sets of practices are not explored well in PHC literature. Although the ICP literature names the importance of considering the context of ICP and the manifestations of power in ICP, I've argued in this chapter that critiques from authors like Fook argue these same considerations need further attention in the literature of RP. This doctoral research makes an early contribution to the intersections between these two practices paying particular attention to the contexts of these practices and the manifestations of power in their execution. The following chapter outlines the important place that reflection has played in the considerations of knowledge and knowing which have shaped this research.

Chapter 4 – Knowledge and knowing

> I believe too much in truth not to suppose that there are different truths and different ways of speaking the truth. (Foucault, 1988, p.47)

The focus of this study is exploring the understanding of ICP held by different professionals in PHC in Aotearoa/New Zealand. Given the widely varying understanding of ICP, as outlined in Chapter Two, a decision was made to utilise a qualitative research approach. Further, the focus upon an exploration of understanding suggested the usefulness of a hermeneutic approach which is increasingly being acknowledged as making a significant contribution to qualitative research (Alvesson & Sköldberg, 2009; Brinkmann et al., 2014). In this chapter, the argument for hermeneutics, and in particular the critical hermeneutics of Kögler is presented. I explain the rationale for drawing on critical hermeneutics and describe key aspects of how knowledge is conceptualised in this theory. Kögler brings together Gadamer's conceptualisation of interpretation-as-dialogue with Foucault's conceptualisation of the practices of power in the structuring of discourses. Before outlining key aspects of Kögler's critical hermeneutics, I begin with a brief introduction to hermeneutics. Then I will go on to consider some of the broad concepts of both Gadamer and Foucault that have particular relevance to this study.

4.1 Hermeneutics

Broadly speaking hermeneutics, as we have come to conceptualise it across the past one hundred years, is an exploration of human understanding and interpretation. This conceptualisation of hermeneutics is based on the work of the German philosopher Martin Heidegger (1889–1976). Heidegger built upon the earlier work in hermeneutics of Wilhelm Dilthey (1833–1911) and Edmund Husserl (1859–1938) to argue that hermeneutics is not something we do, but is rather the way we exist in the world as interpreting beings (George, 2020).

Hermeneutic thinkers challenge the idea that the knowing subject is separate from a knowable world. Instead, hermeneuticists argue that people are acting subjects and their practical participation in the world involves constantly attaching meanings to their experiences through the language used by themselves and others. In this way it has been argued that hermeneutics is fundamental to qualitative research (Alvesson & Sköldberg, 2009; Brinkmann et al., 2014; Diesing, 1991; Kinsella, 2006).

A particular focus of hermeneutics is examination of language that is documented in text, though as Diesing (1991) explains, this idea of text also includes "any human action, product, or expression that can be treated as text" (p.105). Hermeneutics does not engage with text in the same way that other theoretical traditions commonly used in the social sciences do. That is, text is not seen as facts fixed in time, or as data that contains truths to be summarized, since, as Patton (2002) posits: "hermeneutics challenged the assertion that an interpretation can ever be absolutely correct or true. It must remain only and always an interpretation" (p.114). In particular, the hermeneutics researcher is looking for a valid interpretation which takes account of multiple meanings of the text and considers the cultural/historical context within which the text was generated (Alvesson & Sköldberg, 2009; Kinsella, 2006). Hermeneutics researchers are thus comfortable with the ambiguity of text and the ways that text will present different meanings to different readers at different times. A key process to assist with management of this complexity is the hermeneutic circle.

The hermeneutic circle is primarily a process employed to enable the interpreter to develop some confidence in the validity of their interpretation of the text. One application of the hermeneutic circle is that the interpreter engages in a constant iterative process of coming to an understanding of parts of the text only through reflexively considering the whole text (Alvesson & Sköldberg, 2009; Kinsella, 2006). This common back-and-forth reflexive process used by the hermeneutic interpreter is described here by Diesing (1991):

> The interpreter eventually fits the particular passages into a connected, coherent story or interpretation. The meaning of each passage comes from its place in the whole story…Some passages in the text do not fit into the story, or raise questions that the interpretation does not answer … a revised hypothesis will suggest other details that need to be found or clarified in the texts; or some detail that fits the first hypothesis may not fit the second. Or the two hypotheses may suggest different interpretations of the same phrase… this back-and-forth process is called the hermeneutic circle. (pp.108–109)

A further consideration of the hermeneutic circle relates to the work an interpreter undertakes to make sense of text in relation to its cultural and historical context. Diesing (1991) explains that an interpreter may not initially be able to move past the puzzling nature of text they are reading, even though they know that "each of the actions and statements means or intends something, and calls for some response, implicitly or explicitly" (p.125). To assist them in their interpretation they can consider the context of the text, including the socio-political and historical contexts within which the texts have been produced, and are being interpreted.

In both of these applications of the hermeneutic circle it can be seen that the hermeneutic interpreter is not a passive recipient of knowledge that emerges from the text; rather, they take an active role in interrogating the text, or as Alvesson and Sköldberg (Alvesson & Sköldberg, 2009) explain, "they use the procedure of asking questions to the text, and listening to it, in a dialogic form" (p.101). This process of asking questions and listening is explored in more detail in the section below, which notes the particular contributions of Gadamer to hermeneutics; however, I make one important point here in relation to the hermeneutic interpreter. The interpreter is not engaging with the text as if they were an impartial observer; Rather, the hermeneutist recognises they come into the process with their own background understanding or foreknowledge. As Diesing (1991) explains: "No knowledge without foreknowledge. That is, we form an expectation about the unknown from what we 'know.' Our foreknowledge may be mistaken, or partial and misleading, or inapplicable to this text" (p.108). Finding ways to make sense of how this foreknowledge/background understanding may be influencing the interpretation of the text is another aspect of the hermeneutic circle. This aspect of hermeneutics is fundamental to Gadamer's contribution.

4.2 Gadamer's hermeneutics

In this section I articulate the main ideas from Gadamer's hermeneutics which have informed the work of Kögler (outlined later in Section 4.5). Hans Georg Gadamer (1900–2002) was a German philosopher of the continental tradition. Initially a student of Heidegger, he later built upon the work of Heidegger to elaborate a philosophical hermeneutics, with a particular focus on uncovering the nature of human understanding. He was interested in how people communicate with each other, and how they seek to both understand and to be understood. Kögler and Stueber (2000) have noted the important impact on the social sciences of Gadamer's hermeneutics, particularly "the hermeneutic rejection of natural-scientific objectivity together with an acceptance of the dialogical and open-ended nature of human interpretations" (p.35).

Gadamer argues that the interpreter (of both a text and meanings expressed in dialogue with another person) is concerned with making sense of whatever is before them, text or words. Sense-making is fundamental to the nature of our being in the world and is reliant on the use of language:

> Language is not just one of man's possessions in the world; rather, on it depends the fact that man has a world at all. The world as world exists for man as for no other creature that is in the world. But this world is verbal in nature." (Gadamer, 1989, p.443)

That is, Gadamer argues we use language in our ongoing relationships with each other, and in doing so we build the world around us. For Gadamer, this is a dynamic process where speakers' use of language enables them to "constantly pass over into the thought world of the other person" (Gadamer, 1976, p.57). Gadamer wrote extensively about the complexity of this process, drawing particularly on the concepts of fore-knowing (sometimes called pre-understanding), prejudice, and the fusion of horizons.

4.2.1 Prejudice and fore-knowing

Gadamer (1976; 1989) argued for a rehabilitation of the historical meaning of the word *prejudice* to take it back to its historical roots where it is neither a negative or positive word and means pre-judgement. In Gadamer's hermeneutics, he notes we adopt prejudices as a consequence of our historical experiences of being in the world. That is, as we experience the world and find the language to attach to these experiences, we build our judgements of these experiences. Over time, these judgements fade into our background understanding of our being-in-the-world as prejudices. Gadamer (1976) notes: "prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth" (p.9), but does argue we need to pay attention. Prejudices are deeply interwoven into our understanding of the world that we have built up across time: "Prejudices are biases of our openness to the world. They are simply conditions whereby we experience something – whereby what we encounter says something to us" (Gadamer, 1976, p.9). If we are to truly seek understanding in our interpretations of dialogue and text, we must pay attention to these prejudices.

4.2.2 Fusion of horizons

Gadamer (1989) argues that a key consequence of our experiential fore-knowing of the world is that we that we develop a *historically effected consciousness*: that is, our consciousness is affected by history, at the same time as our consciousness is brought into being (effected) by history. This historically effected consciousness proves to be an important part of Gadamer's theorising of hermeneutics with one component being how the historically effected consciousness is integrated into people's present experience of being in the world. Gadamer uses the metaphor of the horizon to assist in his argument:

> The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons. (Gadamer, 1989, p.302)

Gadamer uses the metaphor of horizon to discuss relationships between a person's past and present understanding of the world. He argues that our historically effected consciousness creates a *historical horizon of understanding* which we bring to bear in our interpretation of text and our communication with others. At the same time, he argues, our horizon of the present is not fixed and is constantly being formed as we continuously re-examine our experiences and our prejudices: "There is no more an isolated horizon of the present in itself than there are historical horizons which have to be acquired. Rather, understanding is always the fusion of these horizons supposedly existing by themselves" (p.306).

Gadamer argues that the fusion of horizons is also a crucial part of the hermeneutic encounter in dialogue and interpreting text. In dialogue, the speakers are constantly seeking understanding through their use of language – they are seeking a fusion of horizons in their understanding with each other. This necessitates each person examining the prejudices that are enabling understanding as well as considering the prejudices that are hindering understanding. Gadamer explains: "In speaking with each other we constantly pass over into the thought world of the other person; we engage him, and he engages us. So we adapt ourselves to each other" (Gadamer, 1976, p.57).

The fusion of horizons is also used by Gadamer to argue the place of misunderstanding within the broader sphere of understanding. Even when communication signals misunderstanding, Gadamer (2007) argues that our ability to have separated out the misunderstanding from previous understanding relies on a prior, shared, social agreement in understanding that has come from a fusion of horizons: "every misunderstanding presupposes a 'deep common accord'" (Gadamer, 2007, p.87). We only notice misunderstanding because of the existing overarching shared understanding.

Gadamer argues that an interpreter of text can similarly seek this fusion of horizons provided the interpreter actively engages with the text through processes of questioning and interrogation:

> The understanding of a text has not begun at all as long as the text remains mute. But a text can begin to speak…When it does begin to speak, however, it does not simply

> speak its word, always the same, in lifeless rigidity, but gives ever new answers to the person who questions it and poses ever new questions to him who answers it. To understand a text is to come to understand oneself in a kind of dialogue. (Gadamer, 1976, p.57)

4.3 Foucault

Michel Foucault (1926–1984) was a French historian and philosopher who has had a significant impact on the social sciences and health (Petersen & Bunton, 1997; Petersen, 2012). Foucault's unique analysis focused on the historical development of knowledge which he often referred to as the genealogy of knowledge production. Petersen (2012) succinctly explains:

> Genealogy seeks to disrupt our conceptions of the present, by drawing attention to how these are reliant on shifting discourses and practices linked to particular operations of power. Foucault understood discourse as a collection of related statements and events, which are a historical manifestation of a particular configuration of knowledge and power. (p.8)

An important body of Foucault's work was applying this genealogical method to the development of the professions in the nineteenth and twentieth centuries. Foucault's examination of the ways power relations shaped the development of knowledge about the body, health and healthcare was a part of this work.

Foucault's analysis of discourses in health attend to the ways in which health is constituted within social, economic, political and historical power relations. His analysis has offered much insight to researchers examining the phenomenon of the medicalisation of health and the power relations that operate in the context of biomedicine. Petersen (2012) argues that the reductionism and individualism that dominate health as a consequence of the power of biomedical perspectives has resulted in "a tendency to see complex problems, involving many facets (socio-cultural, psycho-social and biophysical; e.g. mental illness), as reducible to biophysical malfunction and as consequently treatable through interventions such as drugs and surgery" (p.15).

4.4 Critical hermeneutics

Critics of Gadamer's work argue that he did not sufficiently consider the critical dimensions of power in his hermeneutics (Gardiner, 1992; Kögler, 1996; Kögler, 1997a; Roberge, 2011). Arguments are made in criticisms of Gadamer's work that when language is

used to make sense of the world in hermeneutics, this does not occur in a power neutral context. In their conceptualisation of the place of critical theory in qualitative research Kincheloe and McLaren (2005) explain the ways that power influences the use of language:

> Criticalists begin to study the way language in the form of discourses serves as a form of regulation and domination. Discursive practices are defined as a set of tacit rules that regulate what can and cannot be said, who can speak with the blessings of authority and who must listen, whose social constructions are valid and whose are erroneous and unimportant. (p.291)

The development of critical hermeneutics is an attempt to seek the middle ground between Gadamer's hermeneutics and the recognition of the influences of power on human interactions that are offered through critical theory. A critical hermeneutics, then, considers the ways that power is manifested within the structures of society, and how these structures play a role in shaping interactions between interpreters. Indeed, Denzin and Lincoln (2013) argue that a critical hermeneutics has the purpose of revealing the power dynamics that are at play in the texts being analysed (p.311).

4.5 Kögler

Kögler (1996; 1997a; 1997b) has developed a theory of critical hermeneutics which draws together the work of Gadamer, focusing on interpretation as dialogue, and the work of Foucault, on the ways discourses are produced through power/knowledge relations. Kögler (1996) explains his thesis as: "an attempt to fuse conceptually the analytical tools offered by discourse analysis and a microanalytics of social power practices with the insights that hermeneutics has gleaned with respect to the nature of preunderstanding and the dialogic character of interpretation" (p.2). Central to his thesis is the importance of reflexivity and its relationship to dialogue. Drawing on Gadamer, he proposes that by entering into a relationship with another person we are enabled to explore ourselves reflexively from a distance. This, in turn, helps us to see aspects of our social world that were previously taken-for-granted.

Kögler's theory of a critical hermeneutics utilises some of the key concepts that are commonly used to explore interprofessional collaborative practice and RP including the following: the importance of acknowledging the subjective experience of the other; the need to explore how the context of interactions influences the individual's perceptions; the relationships between the individual's perceptions, the context of their present interactions and their previous understandings and experiences; the relationships between language,

power and the meanings attached to experiences; the relationships between knowledge, societal structures and subjective experience; and finally, the importance of different reflexive modes and how these may lead to exploring social goals in quite different ways. These key concepts are explored in the following sections which describe Kögler's conceptualisation of three different levels of social reality and the three modes of reflexivity of person-to-person interaction within these three levels of social reality.

4.5.1 Objective, structural level of social reality

The first of the three levels of social reality defined by Kögler (1997a) is the objective, structural level which influences (and can constrain) social interactions: "objective constraints with regard to realisable action plans and life opportunities" (p.142). The objective structural level of social reality is sometimes described by Kögler as the structural environment and can include people's incomes, professional contexts, housing environments and political structures. He identifies, thus, the importance of external constraints which are imposed on the lives of individuals and the way that these economic and cultural structures create differential access to the resources required for living and social interaction. Consideration of the structural level of social life is fundamental to work in the health and social services, particularly in PHC where social determinants of health have been well documented. Although much of the work in PHC occurs at the level of the individual, I will show in the following chapter that there are broader concerns in PHC which intersect strongly with this objective structural level of social reality.

4.5.2 Deliberate action and conscious belief

Kögler's (1997a) second level of social reality is where people "consciously and intentionally pursue actions or express meanings" (p.143). This level of social reality is concerned with deliberate actions, speech practices and conscious beliefs. In explaining this level, Kögler refers to examples of communication processes and interpersonal relationships where people think about, talk about and act upon the world in deliberate ways. It can be seen that the actions of practitioners working in PHC (the context of this study) fit into this level of Kogler's theory. Through education and training processes, health professionals are trained in actions, practices, communication processes.

Although Kögler acknowledges the importance of individual human agency, he argues that these deliberate social practices are still shaped by one's objective structural social reality. That is, contexts impose a certain structure upon social actors and delimit their

access across time to economic and other resources. Kögler does not, however, reduce the relationship between objective structural social conditions and conscious action to a causal one. Instead, he proposes that deliberate actions and conscious beliefs, are constructed through a reflective-consciousness, explained further below, drawing upon the third level of social reality Kögler's interpretive schemes.

4.5.3 Background social reality (interpretive schemes)

The background social reality that Kögler often refers to as 'interpretive schemes' draws upon Gadamer's ideas about fore-knowing and prejudice. Kögler describes the interpretive schemes as providing social actors with patterns of meanings and understandings that are organised through the deep-seated conceptions held about society, nature and selves. People draw upon these schemes, without conscious thought, through their beliefs, values and actions. Since people organise their thoughts as well as their intended actions on the basis of these largely implicit, interpretive schemes, Kögler often refers to them as the subject's background.

Kögler's understanding of 'interpretive schemes' is that they act as mediators between the first and second levels of social reality (objective structural level and deliberate action and conscious belief). Kögler (1997b) explains: the interpretive schemes are "*symmetrically placed in between intentional acts* (that draw on such schemes to make sense) *and social conditions* (that shape such schemes by imposing a certain structure on them in each individual)" [emphases in original] (p.233). In the same way as Gadamer's prejudices, Kögler argues that people are not necessarily aware of all the assumptions and consequences of these background interpretive schemes. Their intuitive understanding and participation in social practices do not necessitate this knowledge. As Kögler (1996) explains:

> The very point of the "thesis of the background" is that subjects think and act on the basis of a largely implicit and unreflective pre-understanding. This background understanding is not directly available to the subjects, nor are the effects and consequences of the corresponding social practices fully understood or controlled by them. (p.257)

It is this hidden nature of the interpretive schemes that leads Kögler (1996) to compare his conceptualisation of interpretive schemes with Bourdieu's notion of habitus. It is useful to comment briefly here that Bourdieu's concept of *habitus* has been applied to professional role socialisation in ways that Kögler's work has not yet been applied

(Emmerich, 2015; Hindhede, 2020; Morberg, Lagerström, & Dellve, 2012). In this study on ICP and RP, attending to the ways that professional role socialisation contributed to background understandings of these practices was an important consideration in the development of methodology discussed in the following chapter.

Kögler (1996) argues that it is important to distinguish between three interacting aspects of the background (pre-understanding) which he summarises as: a symbolic sphere of basic beliefs and assumptions, a practical sphere of acquired habits and practices, and a subjective sphere reflecting biographical events and experiences. Kögler (1996) proposes conceptually distinguishing between these three spheres of background understanding enables an analysis of "how social power structures, rooted in social practices and institutions, leave their mark on particular symbolic forms that define reality for the agents independently of their awareness of social influence" (p.251). This analysis is described further in Sections 4.5.4, but first I describe key aspects of these three spheres.

4.5.3.1 The symbolic sphere of our beliefs and assumptions

The daily social interactions and thoughts rely on internal, un-reflected-upon symbolic understandings of who we are and what it is we are encountering in our daily life. That is, "subjects organize their explicit thoughts as well as their action-oriented intentions on the basis of largely implicit interpretive schemes" (Kögler, 1996, p.258). Drawing upon Gadamer, Kögler argues that it is difficult for people to reflect upon what it is they really think about or assume is happening to them or those around them because these symbolic schemes have been built up over their lives and filter every experience they have. The symbolic orders or symbolic schemes which people create lie underneath their interpretations and actions. As such, they are important since they are the representations that they have which define their reality. Kögler (1996) sees these symbolic orders as both shaping and enabling people to participate in their social life with others. He also identifies language as one of the fundamental aspects of their symbolic sphere.

4.5.3.2 The practical sphere of our acquired habits and practices

Kögler explains the practical sphere of pre-understanding as the background interpretations of social actions built up from past experiences. This practical pre-understanding shapes what people do and say. Whereas the symbolic sphere of pre-understanding creates a background *horizon of intelligibility*, the practical sphere shapes

unconscious consideration of what is seen as natural and legitimate action. Kögler (1996) provides three examples which demonstrate the links between the symbolic and practical spheres of pre-understanding; based on a background symbolic understanding, these practices are rendered natural and legitimate in a background practical understanding.

Table 5

Links between the symbolic and practical spheres of pre-understanding

Symbolic pre-understanding	Practical pre-understanding
Madness is disease	Therapeutic treatment for madness
Criminal behaviour is character based	Imprisonment of drug users
Class/gender distinctions are natural	Salary divisions according to division of labour

4.5.3.3 The subjective sphere reflecting biographical events and experiences

Kögler's critical hermeneutics is especially interested in the subjective aspect of the background hermeneutic self. He describes how everyone has lived their lives within particular structural circumstances and through the journey of their lives have built up an internal understanding of who they are, where they have come from, and where they fit in the objective structural level of society. These images people have of themselves both enable and limit their interactions with others in ways that they do not need to think about as they have become a part of how they see themselves and their relationships to others.

4.5.4 Exploration of the relationships between the three levels of social reality

Kögler's explorations of the relationships between people, their socialisation, actions, perceptions of their actions and the structures of society are important considerations for professionals who are critically reflecting on their ability to collaborate with others. Kögler (1996) argues that even though people are 'autonomous co-subjects' and therefore practice according to their own conceptions of what is right and proper, our conceptions may, in fact, be undermined, constrained or enhanced by the concrete contexts within which they find themselves. This is an idea that is essential to consider in examination of professionals' interactions with each other.

If we accept that 'meanings' are tied to the social contexts in which people are immersed when they create meanings, it follows that professionals have a responsibility to explore the validity of their thinking and behaviour within the context of their occurrence. Kögler (1997b) explains: "I argue that intentional acts, whether rendered as speech acts,

perceptual acts, or acts of practical involvement, are always embedded in a meaningful context that provides a symbolic-practical background for social interaction" (p.224). He uses the term, 'contextual adequacy,' to stress the importance of striving to investigate the adequacy of symbolic schemes to the situation being experienced; That is, people need to be very clear how congruent symbolic schemes are to their objective social conditions.

It is this third aspect of pre-understanding - being grounded in contextual meaning - that creates a dilemma. If actions are always tied to pre-understandings, which themselves are grounded in specific contexts, how will it ever be possible to analyse the power which manifests itself in social relations? In other words, if it is accepted that people are located within particular contexts which have shaped their values and beliefs, how is it possible that these same people can put these same values and beliefs aside to critically reflect on their situation? As Kögler (1996) himself summarises: "the subject is obviously supposed to be both situated and distanced, engaged and critically reflective, immersed in a specific context while analytically observing the structural implications of that very context" (pp.267–268). This dilemma provides the basis for the most important part of Kögler's critical hermeneutics and, indeed, for the aspect of his theory which makes it particularly relevant to this exploration of ICP and the potential contributions of RP to ICP in PHC. He contends that the solution to working through this dilemma lies in the use of a dialogic model.

4.5.4.1 Dialogic model

Kögler (1997a) proposes that it is through communication with someone who is outside of a person's own internal symbolic order that enables them to reflect upon, and gain an understanding of, their own symbolic background. Since one's stance always depends on their own pre-understandings, one is only able to analyse the 'power' that is manifested at the structural level when they explore their social reality in a reflexive process with another. The outsider, through communication with another, finds words to explain, reconstruct or respond to what they are saying or experiencing. Responses to their comments enable them to explore hitherto unexplored symbolic-practical backgrounds (Kögler, 1997b).

Kögler argues (1996) that through the dialogic process what were once hidden symbolic forms may become evident. He suggests that this dialogic approach with another makes it possible for people to undertake a reconstruction of the shared symbolic understandings of social life. It also allows them to distance themselves sufficiently from their backgrounds so that they are able to apprehend, in new ways, the manner in which

social practices have influenced their self-understanding. That is, a dialogic relationship with another can enable people to see those aspects of their background which inform the social practices they engage with. For example, they may be enabled to see, through the relationship, that there are aspects of their backgrounds which are exploitative, exclusionary or based on structures of domination. Through the hermeneutic encounter people are empowered to re-construct their beliefs and assumptions in light of the dialogue that they have with another.

Kögler (1997a) suggests that the person with whom one engages must, to some extent, be in an outside position to themselves, a position that he defines as "the relative outside-position of the situated interpreter" (p.162). In other words, they must be someone who is likely to have different interpretive schemes to use which inform their social practices. This is necessary since Kögler rejects the ideas of it being possible for someone to act as an objective, free-floating intellectual. Kögler (1997b) argues, therefore, that people need to explore their understandings with someone who has been situated in their own particular context and who has interpretive schemes they are not familiar with: "The natural unfamiliarity that the interpreter experiences with regard to the other and his or her taken for granted assumptions and practices provokes the explicit reconstruction of such background structures" (p.245). It is only through having a dialogical encounter with someone who is a relative outsider to one's own context that people are enabled to effectively explore their own position and understandings.

The communication with someone who is a relative outsider to one's own symbolic order, helps to gain some distance from oneself and, thereby, see oneself more clearly. Once some distance has been achieved from the situated-biographical self, Kögler (1996) proposes that the two parties who are in dialogue are able to identify how their assumptions are influenced by the effects and functions of structural power. It is possible that the exploration of these power structures may lead to power relations being defined as oppressive. It is the reflexive nature of the relationship between two people having the potential to develop useful and new ways of thinking and being which Kögler explores in his delineation of three modes of reflexivity which I now go on to explore.

4.5.5 Kögler's three modes of reflexivity

I have shown that Kögler's notion of the dialogic encounter with another has the potential to adequately describe the importance of the professional's focus on the subject-

subject relationship with another. Kögler identifies this relationship as the critical-hermeneutic encounter. As he explains the potential benefits of a critical-hermeneutic encounter, he has delineated the potential modes of the reflexive encounter: instrumental reflexivity, practical reflexivity and structural reflexivity. Kögler (1997b) suggests that progressing from instrumental reflexivity through practical reflexivity to structural reflexivity is a transition in increasing degrees of complexity and abstraction.

4.5.5.1 Instrumental

In the mode of instrumental reflexivity, a person reflects on the ways and means to achieve their social goals. However, in this mode there is no questioning of what those social goals are. They are, thus, reflecting on the best ways or techniques to achieve goals – goals which they have already accepted or taken-for-granted. There has been no distancing of oneself from the goals or from the source of those goals. Kögler (1997b) gives the example of a person thinking about the diet that he/she is on and realising that he/she is not losing weight. This person's reflection upon the experience leads to the conclusion that a new diet should be tried.

4.5.5.2 Practical

In the second mode of reflexivity that Kögler (1997b) posits, persons reflect upon the goals and values that inform their actions. They make judgements about those goals and values and either reject, expand upon, or accept them. In this mode, a step is taken backwards from the situation and a conscious effort is made to determine which goals to pursue. Persons are, thus, opening themselves to other possibilities and other directions.

I argue that PHC professional practice is particularly concerned with this level of social reality. The consideration of whose goals the professional is working towards can create fundamental dilemmas for the professional. Professional training and education, therefore, emphasise the importance of developing good professional judgement and a conscious repertoire of practice theory to assist the worker in managing competing agendas. If professionals do not cultivate this conscious reflection upon goals and actions, then their practice may end up fulfilling goals that are unhelpful to the clients themselves.

4.5.5.3 Structural self-reflexivity

In this third mode of reflexivity (which Kögler also calls critical reflexivity) people reflect on how the goals and values that shape their life and their actions have come to be. Kögler (1997b) argues that people must recognise the importance of the connections between the individual and their socio-cultural environment. Kögler (1996) identifies this process as the critical practice of self-distanciation, which he defines as bringing "about a heightened insight into usually hidden linkages between symbolic relations and social networks of power" (p.252). He is arguing that our socio-cultural context has shaped much of how people see themselves and, therefore, need to create some distance from their understandings of themselves so that they can more effectively see the objective structures of their social reality. This mode requires an acknowledgement of the impact of non-reason on the everyday practice of lives or an awareness of the amount of non-autonomy in lives. Structural self-reflexivity enables an exploration of why certain goals and values are enforced differently according to who a person is in society, what they are doing and where they are placed.

In this mode of reflexivity, people need to consider the contextual position that they find ourselves in and how being in this context has shaped and influenced their lives. There are difficulties in being able to effectively consider these structural contexts, however, because of the situated nature of background understandings. Kögler explains that this mode of reflexivity challenges the notion that people are automatically in a position to make judgement calls about their values and social goals which the practical mode of reflexivity implies that they are able to do. The structural mode of reflexivity confronts people with the idea that they may not automatically be free-standing, deliberative, practitioners who are in a position to rationally assess which means or what ends are good or reasonable (Kögler, 1997b). This aspect of Kögler's theorising is a challenge to Gadamer's historically effected consciousness and the potential to seek a fusion of horizons with another.

To enable people to adequately reflect in this structural manner, they are, therefore, required to make a certain break with their own accepted understandings, and see how their social conditions have both influenced and shaped their lives and their ability to reflect upon their lives. Since one's stance always depends on their own pre-understandings, they are only able to analyse the 'power' that is manifested at the structural level when they explore their social reality in a reflexive process with another. Through the dialogic process,

discussed earlier in this chapter, what were once hidden symbolic forms may be seen (Kögler, 1996),

4.6 Conclusion

I began this chapter outlining the relevance of hermeneutics to a study of this kind which focuses on exploring the understandings of the practices of ICP and RP to different health professions working in PHC. Knowing that Kögler's critical hermeneutics draws specifically on the work of Gadamer and Foucault, I briefly outlined in this chapter some key concepts of their work that he has woven into his critical hermeneutics. There are strong connections between Gadamer's focus on communication and the conceptualising of ICP discussed in Chapter Two. Gadamer's hermeneutics is built upon a thorough explication of how people communicate focusing on how they seek to understand and be understood. This seeking to understand and be understood is fundamental to the themes of sharing, partnership, interdependence, and the nature of ICP as an evolving process which are discussed in Chapter Two.

Kögler has incorporated key considerations of Foucault's analysis of the practices of power and domination into his theorising. In Chapter Two I drew upon the work of Orchard et al. (2005) and Karam et al. (2018) to show that considerations of power are essential in the conceptualising of ICP. It is only through recognising the ways that power can affect interprofessional relationships that potential collaborators are able to consider ways to move towards respecting and trusting each other enough to collaborate effectively.

The final component of Kögler's theorising that intersects strongly with the focus of this study on ICP is his argument that dialogic encounters with another provide the opportunity to carry out a structural self-reflexivity. In the context of ICP, a structural self-reflexivity enables professionals who are striving for ICP to attend to how their own goals, values and backgrounds shape their contributions and conceptualisation of ICP. It is only through this structural self-reflexivity, Kögler argues, that people can make a break with their own accepted understandings of social interactions. This process I showed in Chapter Two is essential for potential collaborators to develop the partnership that is required for ICP.

In the following chapter I outline key decisions made with regard to methodology, research design and methods that were consciously informed by Kögler's delineation of the

three different levels of social reality, and the three different forms of reflexivity that are possible in a dialogical encounter with another.

Chapter 5 – Research design, methodology and methods

5.1 Introduction to the chapter

Key decisions that were made in establishing the research design are outlined, and the methods of data collection justified and summarised. A rationale for these methods is presented, based on the theorising of the previous chapter. I explain the decisions made with regard to selecting people to interview and documents to utilise. Finally, I detail the analysis used to make sense of the data collected.

In several places in this chapter, I refer to iCOACH, the large international research project referred to in Chapter One. iCOACH was exploring innovative models of integrated care within community-based PHC settings in Canada and Aotearoa/New Zealand. Initially the iCOACH team and myself saw potential overlaps between their study and my focus on interprofessional collaborative practice and so it was decided to incorporate my study as one strand of this larger project. This relationship is visible in the ethics and recruitment of participants sections of this chapter. As my doctoral research progressed, however, the two studies diverged in their epistemologies and method, and I moved increasingly away from the iCOACH project.

5.2 Research design decisions

As I have argued in the previous chapter, this research is framed by the critical hermeneutics of Kögler, noting that hermeneutics is increasingly being applied to research exploring interpretive acts in human and social sciences (Rorty, 1991). In this chapter, I further explain decisions made in research design, choice of methods and processes of implementation and analysis which were founded on this theoretical base.

The focus of hermeneutics on the importance of interrogating language, exploring its multiple meanings, and considering its reflexive contexts, make it a particularly useful analytical lens in research where there are a number of different voices in different contexts expounding meanings, as in the present study on ICP and RP. These aspects have influenced framing of the research question and objectives, as well as the choice to focus on text and discourse analysis.

5.2.1 Text

Adopting a hermeneutic approach to research inherently means there is a focus on text and dialogue. A range of texts was selected for analysis in this study (detailed in Section 5.3). One key corpus of text was that produced through the interviews. The clear links between hermeneutics and dialogue is explained by Kvale (1996):

> Hermeneutics is then doubly relevant to interview research, first by elucidating the dialogue producing the interview texts to be interpreted, and then by clarifying the subsequent process of interpreting the interview texts produced, which may again be conceived as a dialogue or a conversation with the text. (p.46)

Thus, the dialogue in the interviews, further discussed below, became the text analysed through the hermeneutic process. An important decision relating to the interviews was to spend more time with a smaller number of people, and through longer interviews to fully explore each participant's understandings of interprofessional collaborative practice and RP.

5.2.2 A discourse approach to my research

My decision to adopt a discourse analysis in this research was informed by Kögler, whose work is particularly concerned with analyses of power and deconstruction. These forms of analysis are relevant for this topic as within the social arena of PHC there is a struggle between the different knowledge claims of different professionals. The different professionals in PHC talk about 'health' and people and the 'problems' they are expected to respond to in their professional work in quite different ways. A consideration of the ways discourses are perpetuated has been an important feature of this study. An overview of different approaches to discourse analysis led me to adopt the sociology of knowledge approach to discourse analysis (SKAD) elaborated by Reiner Keller (2013) as most appropriate to this study.

5.2.3 Research questions

1. What do health professionals working in PHC in Aoteaora/New Zealand mean when they talk about ICP?

2. In what ways do health professionals working in PHC in Aoteaora/New Zealand see RP contributing to or advancing ICP?

3. How have wider discourses of PHC shaped the meanings of ICP and RP as articulated by health professionals working in PHC in Aoteaora/New Zealand?

5.2.4 Ethics

This study was included in the application for ethics approval of the iCOACH study in 2014 in which I was an active participant. Approval from the University of Auckland Human Participants Ethics Committee (UAHPEC) was granted on 12th November, 2014 (UAHPEC Ref.013071).

As data gathering began in early 2015 it became clear that potential participants relevant to my doctoral study were not being included in the recruitment processes of iCOACH. An addendum to the original UAHPEC ethics approval was sought in May 2015 to enable me to interview this additional group of providers relevant to my research. Participant and consent forms approved for the iCOACH study were revised and a modified recruitment process developed. These changes resulted in the development of a different participant information sheet (Appendix B), consent form (Appendix C), and interview guide (Appendix D) which all focused more explicitly on collaborative practice and RP. Approval for these addenda was requested and granted on 23rd June 2015.

The following ethical principles were observed in the application for ethical approval and were maintained throughout the study: participation in the study is voluntary; due regard to cultural mores in interviews needed to be considered; and anonymity and confidentiality of participants needed to be maintained. I informed all participants that their participation was voluntary, and they could withdraw their interest at any time up to two weeks after their interview or after receiving a transcript of their interview. Consent to participate was obtained in writing.

Due regard to cultural mores in interviews and data management was deemed important due to the high numbers of Māori and Pacific peoples seeking PHC in this country and ongoing concerns about the inequitable provision of health care services. I have had much experience in working with Māori and Pacific peoples (as well as people from many other cultures) and considered carefully cultural mores with regard to making contact, face-to-face interviews and management of data.

Anonymity and confidentiality of participants was prioritised. I de-identified information related to location, names of organisations and names of people that I used in

my summary and analysis documents. I notified participants of these processes but also advised them that due to the small size of the New Zealand health system and the organisational and professional positions of some key informants, I was not able to guarantee anonymity.

5.3 An overview of methods of data collection (Corpus building)

To generate text for analysis a series of decisions was made about the sources and types of data that would be most relevant for this study. These decisions were made both in the planning stage of the research and during implementation. Three principal types of text were used. First, I carried out semi-structured interviews with a variety of professionals working in PHC and converted these to text. Second, I accessed key documents that these professionals referred to in these interviews (e.g. an evaluation of the gout project at Site One; a report commissioned by the District Health Board at Site Two pertaining to re-organisation of PHC). Third were the texts that were generated through the research process itself (journal notes, field notes and memos). The methods of selecting data, and the rationale for these, are explained below.

5.3.1 Semi-structured interviews

I was interested in obtaining a richness and depth to participants' perceptions, attitudes, beliefs and feelings about ICP and associated RP. I was also interested in how these participants' stories of these practices connected to wider discourses of PHC. One of the most common ways of obtaining such richness of data is through semi-structured interviews and this was chosen as my primary method of data collection. A draft interview guide was developed after considering the literature on ICP and RP and considering the hermeneutic nature of this study. As part of the process of developing the interview guide, different health professionals offered critique on the overall content, ordering of sections, and specific items in the interview guide; these people included a general practitioner, a social worker, a nurse, and a physiotherapist.

In developing the interview guide, I decided to adopt an interview style which was concordant with the interpretative hermeneutic focus of the study. I was guided in this decision by the work of Rubin and Rubin (2012) who argue the relevance of the responsive interview to certain kinds of research:

> Responsive interviewing is a style of qualitative interviewing. It emphasises the importance of building a relationship of trust between the interviewer and interviewee that leads to more give-and-take in the conversation. The tone of questioning is basically friendly and gentle, with little confrontation. The pattern of questioning is flexible; questions evolve in response to what the interviewees have just said, and new questions are designed to tap the experience and knowledge of each interviewee (p.37).

The interview guide was therefore constructed knowing that this was the style of interview which was most concordant with the hermeneutic theory informing this research. As a result of this development work, the guide consisted of three sections, each containing the main questions I wished to explore. Many of these questions contained additional probes identifying particular areas I hoped the participants might talk about. My aim was to develop an interview environment where I could explore fully the interviewees' understandings of the topic areas and obtain rich stories of their experiences, rather than end up with data that were succinct, general, or distant from their experience.

In the interviews themselves, I adopted a friendly conversational approach with the intent of putting the interviewee at ease and allowing spontaneous explorations in the dialogue of the interview to develop depth, detail, and lived examples of ideas. This allowed me to realise the vision of a responsive interview as articulated by Rubin and Rubin: "in the responsive interviewing model, you are looking for material that has depth and detail and is nuanced and rich with vivid thematic material" (2012, p.101). All data collected were converted to text and imported into MaxQDA software to facilitate analysis, further described in the Data Management Section.

5.3.2 Accessing of other texts indicated through the interviews

The interviews with participants yielded important understandings of the topic that, when considered alongside the expectations of professional bodies, went some way to addressing the research questions. However, other documents were identified which would provide further depth to the narratives of the interviews. Sometimes these documents were specifically referred to by participants, for example, the report on the pilot gout project in Site One. In other instances, I actively sourced these documents to assist with my interpretations of data as I was making sense of contexts that were outlined in the interviews. For example, there was an important review of hospital and PHC services in Site Two which provided contextual understanding of how and why one practice resisted amalgamation into the new PHC infrastructure that was developed in their region.

5.3.3 Other documents generated through fieldwork

The final collection of text was that generated through the research process itself. This textual data took the form of journal notes, field notes and memos. The journal notes and field notes were mostly written within the cloud-based software called Evernote. This software being accessible through my cell phone, iPad and desktop computers enabled easy documentation and automatic file and folder synchronisation. As for interview data, the memos were imported into MaxQDA. All electronic devices are password protected and have up-to-date antivirus software maintained.

5.3.3.1 Journal notes

Early in my research journey I decided to separate out field notes from journal notes. I used my journal notes to track and reflect upon my experiences, thinking about my research and insights along the way. In this way my journal entries are sometimes a little distant from the fieldwork itself, but are also very personal reflections of my research thinking. I gave myself permission for these entries to include reactive and emotional content as well as rational content. Consequently, there is a mix of thoughts, fears, hopes, moments of confusion, and reflections upon breakthroughs included in these entries.

5.3.3.2 Field notes

Whilst visiting study site premises to carry out interviews, an additional source of data involved the documentation of observations. These notes on observations during fieldwork became especially important as I moved into analysis, as they assisted with a deeper understanding of the contexts of the interpretations. These observations were informed by ethnographic field strategies which note the importance of both attending to the physical setting, and adopting a reflective stance to one's surroundings and conversations whilst in the study site environment (Berg, 2007).

In addition, I used these entries to write early notes on preliminary analysis, interpretations of what I was encountering and early impressions of people and processes which related to the research questions as recommended by Flick (2014). The structure and content of the field notes were also informed by several consultative conversations with a

socio-cultural geographer, Dr Robin Kearns[6], that were undertaken prior to fieldwork as a result of my growing interest in the context evoked by the text. Attention to the "institutional, organizational, and situative" contexts within which the text was produced is an important feature of the SKAD adopted in this study (Keller, 2013, p.110). These contexts are also an important feature in the theorising of interprofessional collaborative practice. It was argued in Chapter Two (Section 2.7.1) that the structural and organisational environment of health organisations impact upon the ICP that occurs within those contexts. Indeed two of the models of ICP examined (D'Amour et al., 2008; Orchard et al., 2005) incorporate significant features of the organisational/institutional context into their models.

Dr Kearns noted that health-care buildings form part of the landscape of PHC and that their form may be as important as their function in the messages they convey. This idea is succinctly articulated by (Yanow, 1995):

> Buildings communicate values, beliefs and feelings using vocabularies of construction materials and design elements... at the same time, spaces are settings for organizational acts... in this way, organizational spaces are both medium and message. (p.408)

These conversations with Dr Kearns led to the development of a framework I called *Place and Space Considerations* (Appendix E) which I carried with me throughout fieldwork to assist me in paying attention, in particular ways, to the places that I visited. These considerations formed one important aspect of reflections that were documented in my field notes and were guided by some broader questions such as 'What stories are evoked by the built environment?' and 'To what extent are the Alma Ata inspired philosophies of PHC visible in the design of the premises that are built to house PHC services?' Also, in recognising that the buildings are both the message (story) and the medium (storyteller) several other reflective questions were considered: What relationships might there be between the layout of premises and processes of collaboration and reflection?; Are there 'spaces' allowing ease of formal/informal dialogue with other professionals?; Are there 'spaces' allowing ease of reflection by self and with others? Later analysis on these aspects has provided the basis for Chapter Eight.

[6] Dr Kearns is a professor at the University of Auckland whose research focuses on relationships between place and wellbeing. His scholarship has contributed significantly to the evolution of the subdiscipline of health geography.

5.3.3.3 Memos

Throughout the time of my analyses, I constantly wrote memos within the MaxQDA software. These memos took the form of what Saldana refers to as "think pieces of reflexive freewriting" (2011, p.98). These memos acted as a first stage of hermeneutic engagement and interpretation upon which I drew significantly during analysis. In MaxQDA it is possible to create four different kinds of memos: those attached to documents; memos attached to codes; memos that are attached to text within your document (for example, a key utterance, statement, or paragraph); and free memos which are not attached to any text, code or document. The software also enables easy sorting, grouping, linking and printing of memos and groups of memos. I developed a labelling system to assist with these tasks. The first part of the memo title identified the type of memo and the second part (following a punctuation dash) identified the more specific content. Among the main categories of these memos, all of which were within other documents, were an example of an emergent patterns of categories, themes and content, possible links between codes, patterns, categories and code choices and definitions. Other examples of memos documented how I related to the text at that time, e.g. feels familiar to my experiences working in health and social services; appears foreign to my expectations of what I thought people would say/describe.

5.4 Sampling and recruitment for semi-structured interviews

Initial recruitment for the semi-structured interviews was facilitated through the iCOACH study. iCOACH had selected three community-based PHC case studies in Aotearoa/New Zealand for the second phase of their international research programme. The three case studies they had selected were chosen to reflect variance across a range of contextual factors to assist them in identifying critical success factors associated with implementation of innovative models of care. The following contextual factors were used: degree of Māori orientation; level of evidence for innovative model being implemented; regional variance; population demographic variance; and level of service integration.

The iCOACH team identified a range of practitioners within each of the case study sites to participate in qualitative interviews. It was agreed that I be a participant observer in several of these interviews. Although the iCOACH interviewers did not ask specific questions about interprofessional collaboratives practices and RP, many stories about these sets of practices were told. Critical reflections on some of these stories prompted the

decision to invite some of these iCOACH participants to be interviewed for my study in collaborative practice.

5.4.1 Sampling

A purposeful sampling strategy to recruit participants was utilised, in preference to representative sampling. As noted by Laverty (2003), selection of participants in hermeneutics studies focuses on choosing people who have lived experience of the topic being researched and who are different enough from each other "to enhance possibilities of rich and unique stories of the particular experience" (p.18). To ensure such people were recruited, a combination of quota sampling and chain sampling was used – both are types of purposeful sampling.

Quota sampling informed my decisions about which professions to recruit into this study. Patton (2002) explains that "quotas are a starting point, a baseline for launching an inquiry, but the size and composition of the sample can be adjusted based on what is learned as the inquiry deepens" (p.285). He goes on to explain that though quota sampling can be flexible it is used as a way to ensure there is coverage of whatever categories are determined to be important for the study design. In this study, the following considerations of 'quota' were made, to ensure that across the participants the perspectives and 'meanings' of the quotas were reflected. There were four overlapping quotas. The first focused on including those providing primary medical care, i.e. GPs, nurse practitioners and practice nurses. The second quota was to ensure inclusion of allied health professionals working in the community, particularly pharmacists. The third quota was to ensure New Zealand trained professionals were included to ensure I was considering understanding related to PHC in this country. The fourth quota was to ensure members of our indigenous peoples, Māori, were included.

The second strand of the sampling strategy was utilisation of 'snowball or chain' recruitment. Miles and Huberman (2002) explain that this sampling strategy "identifies cases of interest from people who know people who know what cases are information-rich" (p.28). This chain recruitment was highly relevant for this hermeneutic study: "studying information-rich cases yields insights and in-depth understanding rather than empirical generalisations" (Patton, 2002, p.264). The first small group of information-rich potential participants for my study was selected from the wider group of practitioners interviewed in the iCOACH study.

5.4.2 Recruitment decisions and process

Utilising the sampling strategy described in above, recruitment occurred across two study sites. In this section I outline the series of decisions I made which enabled me to follow the threads of collaboration between and across organisations and to recruit participants at each study site who were general practitioners, nurses, and allied health professionals of different genders and cultures. I was conscious also that some participants had undertaken their professional training in New Zealand and some in other countries. These considerations of potential participants were recorded in my research journal and though not used as recruitment criteria, they informed decisions on further recruitment in light of the richness of data.

5.4.2.1 Site One

Recruitment at Site One began with two people who were being interviewed in the iCOACH study: a nurse practitioner at an iwi provider; and a GP at a general practice which identified itself as an Integrated Family Health Centre[7] (IFHC). The iwi provider is a not-for-profit tribal organisation that provides community-based PHC (including social services) for people within their tribal boundaries. The iwi provider also provides a series of nurse-led clinics and employs one of the few nurse practitioners located in their region. It operates across a wide geographical area defined by old tribal boundaries, and includes both rural and urban communities. Two neighbouring suburbs on the outskirts of the provincial town became the primary locus of my attention. One of these suburbs contained the head office of the iwi provider and also one of its clinics. The neighbouring suburb contained the IFHC.

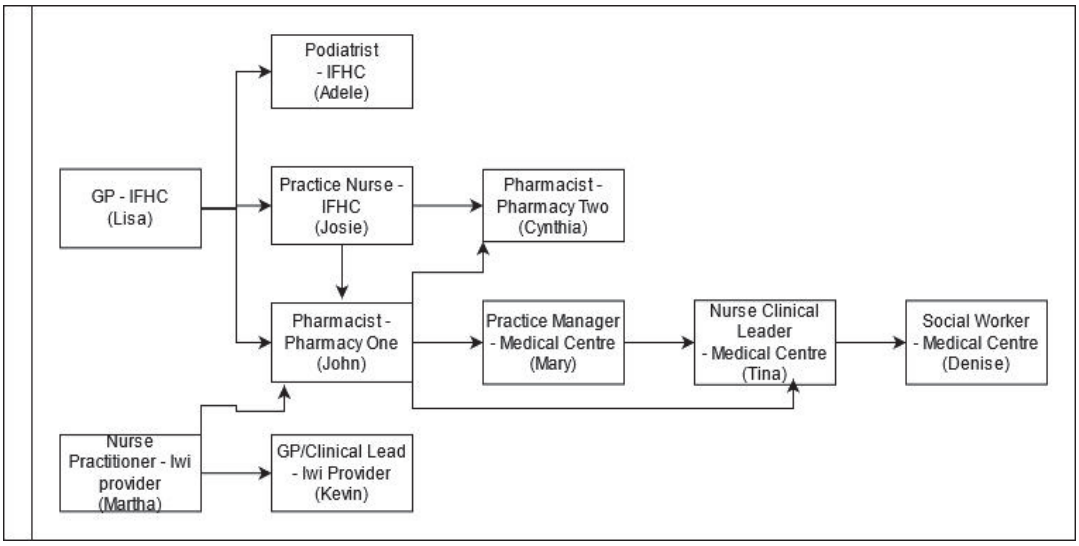
In their interviews, the two practitioners told stories of RP and interprofessional collaborative practice as they answered questions from the iCOACH interviewer, even though they were not specifically questioned about these practices. This prompted me to invite both these practitioners to participate in a follow-up interview on the ICP and RP that they spoke about. At each of these follow-up interviews I reflected back to the participants the stories they had told about collaborative practice and asked them with whom they were collaborating. This provided an additional pool of potential research participants. In consultation with my supervisors, decisions were then made on which threads of chain recruitment to follow. Different participants sometimes named the same people. For

[7] These are a particular type of general practice established under a funding scheme that is described in Chapter Six.

example, at Site One the first pharmacist was named by the initial GP and by the nurse practitioner interviewed. The same pharmacist was also named by the practice nurse of the IFHC. This pattern of chain recruitment it outlined in Figure 3.

Figure 3

Chain recruitment process at Site One



Ultimately eight women and two men were interviewed. Two of the staff had been professionally trained in both New Zealand and overseas. All other staff were New Zealand trained and educated. None identified as Māori, though one was a Samoan woman married to a Māori man. Eight of the interviews occurred on the work premises of the practitioners. Two of the ten interviews occurred in venues outside of the participants' normal work site at the request of the participant: one of the GP interviews was at the home of the GP; one of the pharmacists came to the premises of the general practice where I was undertaking other practitioner interviews on the same day.

5.4.2.2 Site Two

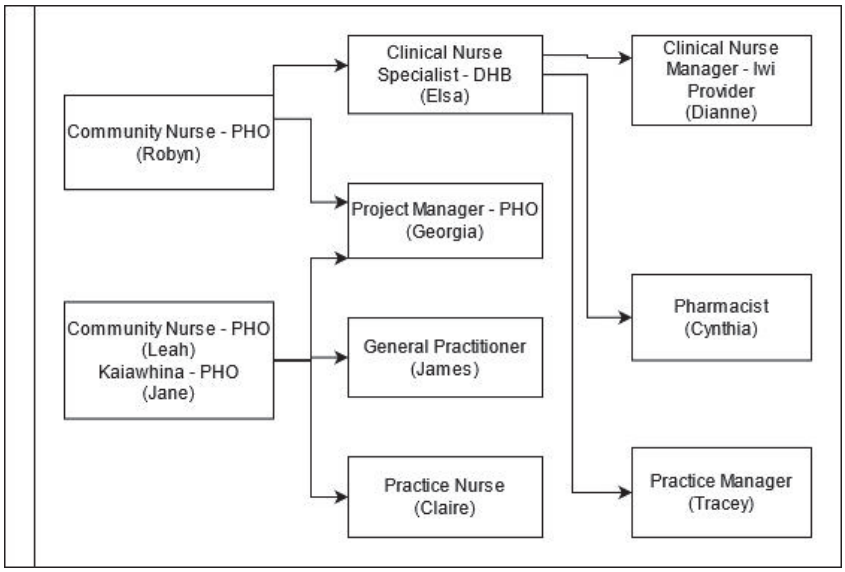
Recruitment at Site Two also began through my reflections as a participant observer in the iCOACH study. Information rich stories about ICP were told by the following: the manager of a community-based support programme in a primary health Ooganisation for people living with LTCs; and a group interview with two nurses and one kaiāwhina who worked on this programme. The highly collaborative nature of the working relationship of these two nurses and kaiāwhina, led to me inviting these three practitioners to participate in

this study. One of the community nurses and the kaiāwhina were interviewed together (at their request). The other nurse was not available at the same time/place and so was interviewed separately. This was useful as it transpired she worked half-time in the community-based support programme and half-time in a general practice. This provided useful insights into the ways community-based providers collaborate with practitioners within general practices.

Chain recruitment continued at this study site as per the process described in the previous section (see an overview in Figure 4). Ultimately, I interviewed nine women and one man in Site B. Two of the staff had been professionally trained in both New Zealand and overseas. All other staff were New Zealand trained and educated. Two of the ten practitioners identified as Māori. Four of the participants worked for the PHO. Two participants worked for one general practice, with one further participant working as a practice manager in a general practice from a neighbouring town. The remaining participants worked in the following organisations: an iwi provider, a pharmacy and a District Health Board (see Table 6 for an overview).

Figure 4

Chain recruitment process at Site Two



Four of the ten interviews happened in venues outside of the participant's normal work site at their request: the interview with the pharmacist was at a local café; the GP was interviewed in his home at a weekend to avoid work busy-ness; one of the community nurses was interviewed in a café near their home at a weekend also because of work busy-ness; the

joint interview with the community nurse and kaiāwhina happened in the premises of a not-for-profit agency that one of the workers was associated with.

5.4.2.3 The organisational contexts of those selected to interview

An overview of the organisation locations of people interviewed is provided in Table 6. In Site One ten people were interviewed from four different types of organisations: a general practice established as an integrated family health centre (IFHC); a General practice named by themselves as a medical centre; an iwi provider providing health and social services; and two pharmacies. All of these organisations, except for the iwi provider, were located within one small suburb of a provincial town. One of the pharmacies operated almost exclusively as a dispensary and had a small staff. The other pharmacy was a part of a national chain, had a larger staff, and had a broad product range across large shop premises. The iwi provider was located in a neighbouring suburb.

In Site Two ten people were interviewed from five different types of organisations: a PHO; two general practices (both members of that PHO); a community health service of a District Health Board; an iwi provider; and a pharmacy. Although the PHO works across a large region, most of the stories particularly related to their work in two small provincial towns, with each of the general practices being located in one of these towns.

5.5 Data management and analysis

5.5.1 Data management

The 20 face-to-face interviews ranged in length from 60 minutes to 125 minutes and were digitally recorded. The digital audio files were labelled anonymously to assist with secure storage. The master list of labels was stored separately from the data in a secure location. The data were transcribed and all participants were offered the opportunity to review and edit their transcripts and notify the researcher of any changes or additions they wished to make. All paper files were stored in a locked cabinet on secure facilities at the University of Auckland. Electronic files were stored on password-protected computers under a University of Auckland username. This included the memos utilised for analysis which were generated within the computer-aided qualitative data analysis software, MaxQDA, loaded on the University of Auckland computer.

Table 6

Organisational locations of people interviewed

		Site One		
Medical Centre (General Practice One)	IFHC (General Practice Two)	Iwi Provider	Two Pharmacies	
Nurse clinical leader/practice nurse Practice manager Social worker	GP/co-owner Podiatrist Practice nurse	GP/clinical lead Nurse practitioner	Pharmacist (x2)	
		Site Two		
PHO	Two General Practices	Iwi Provider	District Health Board	Pharmacy
Project Manager Community-based nurse (x2) Kaiāwhina	GP/co-owner Practice nurse (General Practice Three) Practice manager (General Practice Four)	Manager	Clinical nurse specialist	Pharmacist

The journal notes and field notes generated throughout the research were mostly documented in cloud-based software called Evernote on my smart phone and iPad. These devices are password-protected. The notes were then available through my password-protected desktop computer to incorporate into analysis. In some instances, field notes were documented in hard-copy journals which were stored in a locked cabinet at secure facilities at the University of Auckland.

5.5.2 Data analysis

Decisions on the processes of analysis were informed by Keller's (2005; 2013) *sociology of knowledge approach to discourse analysis* (SKAD). In particular, my focus was upon the ways language is used in the texts, the relationships between language use and contexts, and how usage connects with larger discourses that are part of knowledge production and reproduction. SKAD draws on the concepts of interpretive schemes, narrative structure and the mechanisms which enhance and maintain the exercise of power within social relations. SKAD is informed by insights from Foucault as well as by the tools of qualitative social research, particularly the social constructionist work of Berger (1991).

Keller (2005; 2013) argues that discourse analysis needs to constantly focus on single utterances in the texts, consider their contexts, and then to use different strategies for detailed analysis of their meaning. This guidance was key in the approach adopted. Key features of these processes in analysis are outlined in the following sections.

5.5.2.1 Contexts of the text

Informed by Keller's (2013) emphasis on the positional state of the texts, that is, the situational, institutional-organisational, and social contexts of utterances made, in this study it was important for me to make sense of the organisations within which the interviewees were located. An analysis of the local and national health infrastructure of PHC in Aotearoa/New Zealand was carried out to provide this initial context (see Chapter Six). This provided a backdrop for the later discussion and analysis which is provided in Chapters Seven, Eight and Nine. The following three levels of analysis contributed to these three chapters.

5.5.2.2 Analysis of the phenomenal structure

Analysis of the phenomenal structure was carried out within MaxQDA. The hermeneutic approach to this analysis required paying particular attention to the relationship between coding and the context of the utterances. That is, paying attention to discovering what Keller (2013) refers to as "genuine categories" (p.118) rather than simply producing lists of paraphrased comments. In discourse analysis the researcher works to ensure that these categories are placed "into a relationship with their conditions, consequences, strategies" (p.118). This exploration of categories, sub-categories, conditions, consequences and strategies all occurred within MaxQDA. This material then informed the narrative analysis described in Section 5.2.3.

Table 7 provides an example of one identification and exploration of a category and its sub-categories that was undertaken within MaxQDA. This example is taken from the text of the interview with the practice manager of the medical centre at Site One called Mary. The following excerpt from the transcript provides the first telling of the *problem solving*. In later parts of the transcript (see other quoted material in the table) she returns to this incident, and speaks of other incidents, where this category of problem solving is visible. The first instance in the text of this category of problem solving is relayed here by Mary.

When I first came across there was there was one particular issue that came up. I went and had a conversation with [the pharmacist] *John to say "what's going on?" He highlighted a few difficulties, and I said, "oh, well that doesn't sound sensible we need to be talking about this" and "let's find a way to do that." And so we did. We agreed on him attending meetings and I sort of just opened the door for that to happen. And um, so really that's where I come from, is that, actually we need to be able to work out ways that we can interact and make it seamless really.*

Table 7

An example of identifying and discovering a genuine category

Category	Sub-categories	Relationships
"Problem solving"	Things not working: • "Things are not working; how do we make this better" • "we need to make that work" • "What's working?" Barriers to things working: • "What's getting in the way?" • "Practical barriers" Being solutions focused: • "There's a solution somewhere" • "If we can't actually address it, what can we do to make it easier?"	Strategies - Mary discusses how collaborative practice is a *strategy* to make things work better - Many references to problem solving used the pronoun "we" Conditions - There are a number of occasions when Mary is talking about 'problem solving' when she also talks about 'reflection'; 'reflection' appears to be a *condition* for this 'problem solving' to occur.

Keller (2005) suggests that there are two main aspects to the phenomenal structure: a dimensional aspect which considers the boundaries or dimensions of how a phenomenon is similar to, or different from, related phenomena; and a content aspect which seeks to describe the attributes, characteristics, and "general or generalisable" aspects of the content. This analytic activity was carried out within MaxQDA using the coding and memo functions of the software. There were three key processes to this aspect of my analysis within MaxQDA. Firstly, all text that appeared to be related to the key concepts of RP and interprofessional collaborative practice were identified through coloured highlighting within the software being utilised.

Secondly, within MaxQDA I used in-vivo coding to identify phrases/utterances that highlighted aspects of the phenomena of RP and interprofessional collaborative practice. At this point I used the memo function of the software to write interpretive comments about these in-vivo codes. Sometimes these memos reflected upon code choices, or on possible links with other categories/sub-categories and conditions (as per example in Figure 5). The

memos also explored possible links with other text being analysed. For example, at Site One I noted in several memos the links I saw between meanings attached to concepts that were identified by both the practice manager, Mary, and the nurse clinical leader/practice nurse, Tina, from the Medical Centre.

Another layer of analysis at this stage of considering the phenomenal structure of the text was considering what was absent. In the following two memo examples the absence of comments in interviews held with three practitioners was noted (the nurse clinical leader/practice nurse (Tina); the practice manager (Mary); and the social worker (Denise) of the Medical Centre at Site One).

Figure 5

Memo examples

> **Memo example 1:** Tina telling stories about the arrival of Mary as the practice manager approximately two years ago and the way she implemented a change management process relating to team infrastructure – Tina thinks this has been significant in shifting interprofessional collaborative practice and reflective practice in relation to critical incidents. Whoa! But Mary makes no direct references to these processes.

> **Memo example 2:** Notions of the family and whanau are noticeably absent in the interviews with Mary. (though thankfully! do appear in transcript with Denise). A reminder that ideas of patient-centred-care are commonly critiqued in this country as being too individualistic (with the wider notions of family that are culturally relevant to Māori and Pacific peoples).

Reading and re-reading of these memos was important in decision-making of the narrative analysis.

5.5.2.3 Analysis of the narrative structure

The second level of interpretative analysis built on the phenomenal analysis documented in MaxQDA and focused on the narrative structures of the texts. The intent of

this level of analysis is to identify narratives that are typical of the discourses that are under consideration. Keller (2013) notes that there is a wide range of different kinds of narrative analysis that can be utilised in discourse analysis, but identified the usefulness in his SKAD of a four-step process which was adopted in this study. First, identifying individual episodes to analyse. Second, carrying out a fine analysis of these episodes through attending to the actors within the narrative structure as well as the time and space elements of plot movements. Third, identification of the main objects that lie at the centre of the actions of the social actors' and what values are demonstrated through the actors' engagement with these objects. Fourth, determination of the narratives that highlight key features of the discourses that are at play.

The first step in this approach involved identifying the individual episodes in the texts that typify the phenomena of interprofessional collaborative practice and RP as articulated by the social actors in their contexts. Critical reflections of the categories, sub-categories and relationships identified within MaxQDA provided the foundation to identify these episodes. I then carried out a fine analysis of these episodes, paying attention to how the individual utterances of the actors attained particular coherence within a main storyline or plot.

The focus on the coherence provided by a main storyline enabled identification of the important objects which lay at the centre of interactions as well as identifying the metaphors used by the actors. In this way, it became possible to consider the social construction of the text, paying attention to the setting of the storyline action. Attending to the setting facilitates a consideration of how the activity of the actors is structured, and the roles of power, time and space. This analysis provided me with the foundation to then interrogate the motivations of the actors as they engaged with key objects in the storyline, thus bringing to the foreground what is valued by the actors in relation to interprofessional collaborative practice.

Determination of the narratives that highlighted key features of discourses at play, required a reflexive process undertaken over time. Initially this involved organising multiple typical episodes into five main assemblages of episodes. These assemblages of episodes were collections of stories that were told by different people about the same process, event, or situation within a specific locality. A consideration of the assemblages of episodes ultimately identified four main narratives:

1. A pharmacist's relationships with two general practices

2. The PHC work of an iwi provider

3. A community-based team provide PHC

4. The re-organisation of PHC in a small provincial town.

The storylines which held together actions in the narratives are strongly connected to the pathways of the chain-recruitment process used to identify participants in this study. For example, at Site One the pharmacist, John, spoke about recent significant changes in his working relationship with the general practice just across the shopping centre carpark from his pharmacy, and he named the particular influences of the new manager of this general practice, Mary, as significant. My recruitment process then led me to interview Mary who told me her stories about a series of events involving that pharmacist (the category of problem-solving explained in the previous section was identified from these stories). The chain recruitment continued in this way with interviews then held with the nurse clinical leader/practice nurse (Tina) and the social worker (Denise) at the Medical Centre at Site One. Similar processes of initial critical reflections upon narratives contributing to recruitment decisions occurred across the research. This led to strong content relationships around a similar process, event or situation.

There were other accounts of the practices of interprofessional collaboration and reflection which are not included in these five narratives. These episodes involved fewer people, were isolated to the 'telling' of one narrator, and were less typical of relationships identified within particular localities and across the two study sites. For example, there was a story told by the podiatrist in Site One about the way she was invited to become a member of a newly established general practice. She also relays the similarities and differences in the ways that she works with practitioners within that general practice compared to those in other districts where she also works. Though these accounts do not appear in the narrative analysis of Chapter Severn they are considered in the analysis of Chapters Eight and Nine.

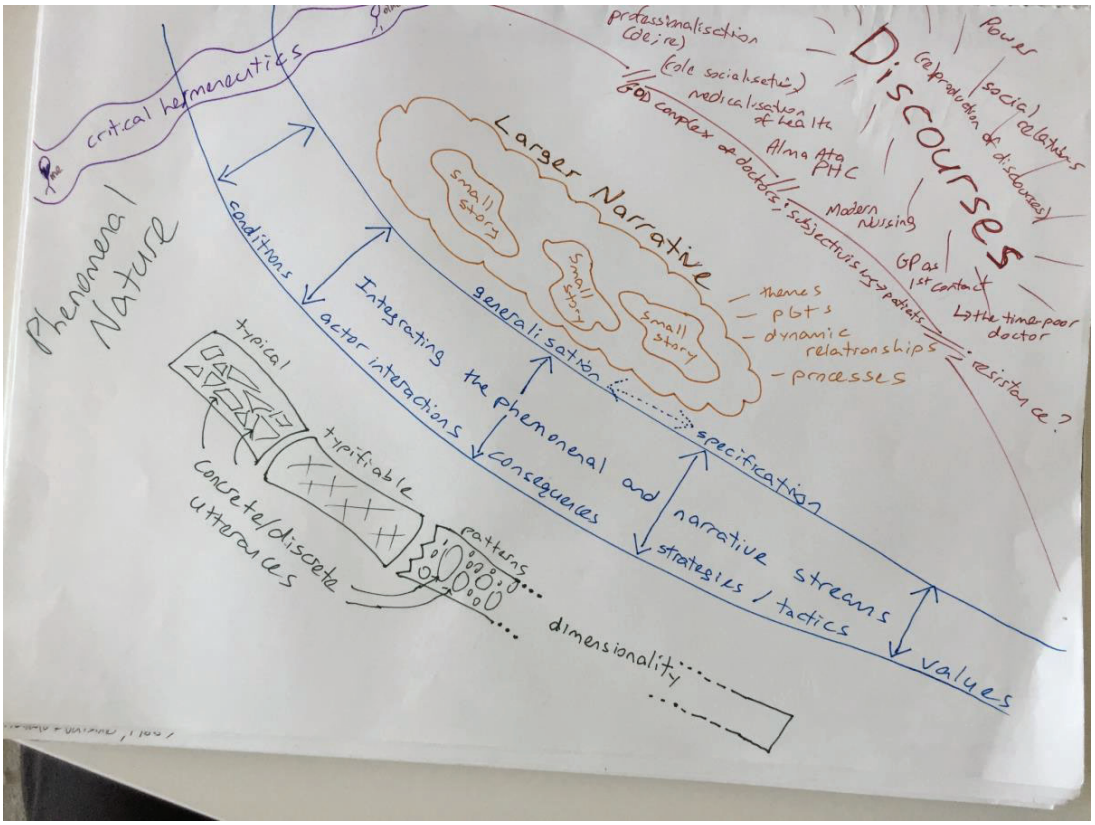
5.5.2.4 Discourse analysis

The primary purpose of implementing the analyses outlined in this section was to determine what discourses were at play in PHC with regard to ICP and RP. An initial map of how I conceptualised this process is included below (Figure 6). The identification of these discourses was thus established through a methodical exploration of the interpretive content of the text using the critical hermeneutic lens argued for in Chapter 4. The intent of the

discourse analysis was not to identify any "true" meaning of ICP or RP, but rather to rigorously examine dominant meanings of these practices within PHC in Aotearoa/New Zealand, then to explore how these dominant meanings continue to constitute ICP.

Figure 6

Mapping of the relationships of the levels of analysis



Drawing on the work of Keller (2013), I paid attention to the following commonly identified aspects as I worked to identify these discourses:

- What were the patterns of stable and enduring social practices that were shaping the interprofessional collaboration and reflection practices of practitioners in PHC? (the ways discourses constitute knowledge)
- What representations of themselves and their profession did practitioners voice with regards to ICP and RP?
- What ways of using language and thinking with regard to ICP and RP were valued and legitimated above other ways? (manifestations of power in discourses)

Three discourses of ICP were ultimately identified and are discussed in Chapter Nine. The discourse of *GP-centred ICP* constitutes ICP through the GP's determination of the patient's need through bio-medical diagnosis. Following diagnosis, treatment by the GP may involve other health care practitioners via ICP. In contrast, the discourse of *Person-centred ICP* constitutes ICP through wider considerations of the needs of people/patients. The views of people/patients are placed at the centre of ICP action. In person-centred ICP, actions can be initiated by a range of practitioners both in and outside the general practice. The third discourse, *Business-centred ICP* constitutes ICP upon the provision of efficient and effective care to patients who are conceptualised as consumers. The business-centred ICP discourse requires the patient/consumer to identify one problem to be met within a ten-minute appointment. Then ICP focuses on an efficient service response to that problem which may involve delegating tasks to other practitioners or making referrals to other practitioners within or outside of the provider's organisation.

Although I had not pre-determined the nature and naming of any of these discourses, I had anticipated that the discourse of biomedicine would likely have some part to play given other discourse analysis work in health over the past few decades has consistently demonstrated this influence. Analysis did indeed identify the enduring legacy of the biomedical discourse with regard to the discourse of GP-centred ICP. This is discussed in Chapter Nine.

5.6 Conclusion

Reflecting the critical hermeneutics of Kögler, decisions in research design considered three different levels of social reality: the objective structural level, the deliberate actions and conscious beliefs of practitioners, and the background interpretive schemes of practitioners. These considerations guided a range of research design decisions including adoption of semi-structured interviews, sampling decisions, and the choice of analytic methods. In particular, reflections upon Kögler 's theorising informed the decision to adopt Keller's sociology of knowledge approach to discourse analysis (SKAD). Reflections upon Keller's approach informed the ways that MaxQDA was utilised to read, re-read and consider the phenomenal nature of the texts. This interpretative analysis of the text corpus then provided the foundation for the narrative analysis which is outlined in Chapter Seven.

Keller's SKAD emphasises a consideration of the positional state of the texts being analysed. Attending to the situational, institutional-organisational and social contexts of the

texts was always an important consideration in this discourse analysis research as informed by Kögler 's theorising on the objective, structural level of social reality. The following chapter (Chapter Six) lays out a careful consideration of this positional state of the texts through an exploration of the landscapes of PHC in Aotearoa/New Zealand. This landscapes chapter provides a backdrop for the later analysis of the text corpus in Chapter Eight which examines the places of ICP that the narrative analysis of Chapter Seven highlighted. Collectively, the analysis of the phenomenal structure, narrative structure, and place of ICP are drawn upon to lay out the discourse analysis in Chapter Nine.

Chapter 6 – Landscapes of the research

6.1 Introduction

This chapter provides a critical perspective on the landscapes of this research to provide a context for the investigation into ICP and RP. A broad view of the overall shape and structure of the PHC system of Aotearoa/New Zealand is considered, paying particular attention to key influences on its development. There are three main sections with the first considering key developments of health policy and health infrastructure that have shaped the PHC system of Aoteaora/New Zealand. The second part of the chapter discusses key features of the funding of PHC. The third part of the chapter considers ongoing difficulties with ICP in PHC given the context presented in the previous two parts.

The terms primary care (PC) and primary health care (PHC) are often used interchangeably. In spite of this usage, there are a number of authors who argue it is important to distinguish between the terms. Muldoon, Hogg and Levitt (2006) have argued persuasively that the term PC generally describes the type of care people receive from a family physician or general practitioner; whereas the term PHC tends to be used when authors are drawing upon WHO explorations of PHC which emphasise the importance of the following four aspects: "universal access to care and coverage on the basis of need; commitment to health equity as part of development oriented to social justice; community participation in defining and implementing health agendas; intersectoral approaches to health" (2006, p.411). I will show in this chapter that although we have aspired to establish a PHC system in Aotearoa/New Zealand, our health system continues to privilege and prioritise PC and the central place of the general practitioner in this care. This tension between PHC and PC has been an important feature of this study.

Given the importance of general practice and the role of the general practitioner in the landscape of PHC in this country, I briefly introduce these here. In Aotearoa/New Zealand there are 36 areas of medicine (called vocational scopes) in which doctors can be registered and work as a specialist. One of these areas is *general practice* and the doctors who register to work in this vocational scope of practice are called *general practitioners* (GPs). The Medical Council of New Zealand (2020) explains that "general practice is an academic and scientific discipline with its own educational content, research, evidence base and clinical activity, and a clinical speciality orientated to primary care." The work of GPs is

carried out in a variety of places, typically in a clinic room located in small community-based premises which are most commonly referred to as general practices. In this country they are also commonly called a medical centre, a doctor's rooms, a family practice or a doctor's surgery.

6.2 The development of PHC in Aotearoa/New Zealand

This section begins by describing the significance of the 1938 Social Security Act which created a national health service with universal entitlement to comprehensive health care in Aotearoa/New Zealand (Cumming et al., 2014; Gauld, 2013). At this time the negotiation between key stakeholders surrounding the passing of this Act provided an important historical foundation on how PHC has been shaped in this country, thus, key aspects of this negotiation are discussed. Then the significance of the strategic leadership of health provided by the Ministry of Health is briefly outlined before critically reviewing the impacts upon PHC of a series of significant health reforms in the 1990s and 2000s. The consequences of these reforms are still evident in the landscapes of PHC today and key features of these are considered to provide a context for the study sites which were described in the previous chapter. One particular consequence of these reforms has been the complex way that PHC is funded so the following section discusses key aspects of this complexity to provide a context for considerations in later chapters of the impacts of this funding upon ICP in the study sites. Finally, this chapter concludes with a critical reflection of the ongoing struggles with ICP in PHC.

6.2.1 The 1938 Social Security Act

Gauld (2013) notes that the 1938 Social Security Act identified a number of values and principles upon which it was based with the following three being particularly related to health: health care should be universally available with equitable access to services; the focus of the health system should be preventative rather than curative; and primary and hospital-based care should be integrated and not fragmented (p.68-69). This vision of the government was not quite to be realised, however, as the New Zealand branch of the British Medical Association (NZBMA) opposed the government's proposed way of funding doctors.

Gauld (2013) explains that the proposed funding was anticipated to be in the form of a "government-funded 'national insurance' that could come via a capitation model that would pay a fixed sum per annum per patient enrolled with a doctor and mean no direct patient charges to see a doctor" (p.71). In this scheme doctors would in essence become

employees of the state. The main argument from the NZBMA was that the personal relationship between the doctor and patient would be undermined as a consequence of doctors attending too much to the needs of the government and not enough to the needs of the patient (Gauld, Atmore, Baxter, Crampton, & Stokes, 2019). Instead, the NZBMA wished to retain the right to have more control over their relationship with patients and to be able to directly charge each patient at the point of service.

Ultimately, the government agreed to a deal with the NZBMA so as to enable implementation of the Act. Whilst free hospital treatment was agreed to, general practitioners (GPs) were allowed to continue their private business ownership model of practice and be able to directly charge patients fees for service. Although government agreed to pay GPs a fee-for-service subsidy for each patient visit, called the General Medical Services subsidy (GSM), GPs retained the right to also charge patients a co-payment. Although efforts were made by several different governments at times in the coming decades to change this situation, Gauld (2013) notes, "in this bargain, we had the establishment of the institutional arrangements that remain in place today" (p.72).

This situation has been of much concern for different governments across the decades, particularly when co-payment charges set by GPs increase. At these times, patients increase their use of the free public hospital system as an alternative to visiting general practices which places burdens on the health system (Gauld, 2001). Quin (2009) argues that these increases in GP-set co-payments have been strongly influenced by GSM benefit subsidies from the government failing to keep up with inflation over time. Concerns about these increases, along with broader concerns about the health system, mounted in the 1970s culminating in the Labour Government releasing the White Paper *A Health Service for New Zealand* in 1974 which proposed a raft of reforms in the health care system.

Easton (2002) reports that general practitioners saw the proposed changes in the White Paper "as a threat to their professional independence and their privately sourced remuneration (that is, a rerun of the concerns of the 1940s)," and the reforms were abandoned with a change of government in 1975. Ten years later when a Labour Party government came back into power (in 1984), the new Minister of Health (the Hon. Dr Michael Bassett) made efforts to place a cap on the co-payments GPs were charging and instead increase the Government subsidy paid to GPs. This renewed effort by government to place a cap on GP co-payments was strongly resisted by NZMA (Quin, 2009) and again, no change occurred.

The combination of needing to pay fees to see a GP, and yet having free public hospitals, is uncommon internationally and has long been shown to create problems of access to PHC services in Aotearoa/New Zealand (Jatrana & Crampton, 2009). Although PHC cost barriers are experienced by many New Zealanders these barriers are inequitably distributed, with higher rates amongst Māori, Pacific peoples, and people living in high social deprivation (Davy, Harfield, McArthur, Munn, & Brown, 2016; Ellison-Loschmann & Pearce, 2006). Later in this chapter (in Section 6.2.4) it is noted that these PHC cost barriers were one of the factors that contributed to the development of the Primary Health Care Strategy 2001. Prior to discussing that strategy and the significant events in the 1990s which led up to the release of that strategy, the following section provides a broader context to the role of government in health and the importance of the place of the Treaty of Waitangi in this country.

6.2.2 Government, strategic leadership and the Treaty of Waitangi

The Ministry of Health is identified as the leader of the health and disability system and advises the Government on health and disability policy and issues (Ministry of Health, 2017b). It carries out its roles through partnership with other public service agencies and particularly through District Health Boards (DHBs) which are discussed further under Section 6.2.4.1. Underpinning this work is the development and promulgation of key documents outlining its strategic intentions for health and disability.

Strategy documents of particular relevance to this research are *The New Zealand Health Strategy 2000* (NZHS) (King, 2000), *The Primary Health Care Strategy 2001* (PHC Strategy) (King, 2001) and *Better Sooner More Convenient* (BSMC) (Ryall, 2007). These documents provided a policy context for PHC service provision across the time of this study and have greatly influenced high-level operational decision-making and funding systems. The implications of these strategic documents upon PHC organisation and provision are discussed in Section 6.2.4. Of note here, though, is that the NZHS and the PHC Strategy continued to name the long-standing stance of the government on the importance of the Treaty of Waitangi to health care.

The Treaty of Waitangi (the Treaty) is the founding document of Aotearoa/New Zealand that was signed by representatives of the British Crown and approximately 540 Māori chiefs on 6th February, 1840. It was a political contract between these parties to found a nation state and establish a national government (Ministry for Culture and Heritage, 2020).

Following the signing of the Treaty, history has documented a relentless series of actions taken by consecutive governments to undermine the Treaty (Walker, 2004).

The 1960s and 1970s saw the emergence of a social movement, often referred to as the Māori renaissance, with a key feature being social activism related to the Treaty (Walker, 2004). Māori called for the Government to recognise the currency of the Treaty, and to redress breaches of the Treaty both past and present. These calls were supported by many others in society. Ultimately in 1975 the government of the day established the Waitangi Tribunal to process claims of the Crown's breaches of the Treaty of Waitangi. Thus began a new era of the place of the Treaty in society, evident in the visibility of the Treaty of Waitangi in the New Zealand Health Strategy 2000 and in the PHC Strategy 2001 (see Section 6.2.4).

One of the seven underlying principles of the NZHS names "the special relationship between Māori and the Crown under the Treaty of Waitangi" (King, 2000, p.7). Under this principle the NZHS identifies key roles for Māori noting they will be able to define their own health priorities and be supported to deliver services to their own communities. Additionally, the NZHS signalled an expectation that DHBs would prioritise the contracting and funding of services to Māori communities. Issues relating to this potential flow of funds from the Government to Māori health organisations are discussed in Section 6.3 as they connect strongly to the interprofessional collaborative practice between organisations in PHC.

6.2.3 Changes to PHC in the 1990s

The 1990s was an important period in the development of PHC. The formation of independent practitioner associations (IPAs) as well as the introduction of Māori health providers and community health centres paved the way for the later development of PHOs. The National Party, elected in 1990, was in power for nine years and undertook a sweeping range of contentious reforms. The impacts of neo-liberal influences and economic restructuring on the welfare state including health were significant, contributing to a significant rise in poverty and socio-economic inequalities reflected in health (Barnett & Barnett, 2004). However, the focus in this discussion is on the quasi-market that was created in the health sector (Ashton & Tenbensel, 2012, p.1). A key plank in the changes was the introduction into the health sector of the purchaser-provider split with competitive contracting of services (Tenbensel, Tim, Cumming, Ashton, & Barnett, 2008). A range of

organisations was established to implement the reforms. This change to contracting arrangements created opportunity for developments in PHC organising which turned out to be significant.

The new contracting arrangements put into place between purchasing organisations and providers created an environment which prompted general practices, then small independent businesses, to organise themselves into collective independent practitioner associations (IPAs) to represent the needs of GPs. Gauld (2008) explains that these "representatives for GPs recognised that sole practitioners would have minimal bargaining power in the contracting process, while the government also acknowledged that it would be inefficient for purchasers to have separate contracts with every individual practitioner" (p.96). IPAs grew quickly in terms of number, size and influence. By the late 1990s they were firmly established in the primary care landscape as organisations that were driven by, and serving the needs of, GPs. Malcolm, Wright and Barnett (1999) estimated that by 1999 approximately 70% of the total GP workforce were members of 21 IPAs. Many of these IPAs became the large PHOs in the early 2000s.

In 1999 the IPAs consolidated their place in the health system through the formation of their national body, the Independent Practitioners Association Council (IPAC). This body operated as a powerful group representing the needs of GPs and general practices throughout the 2000s.

> By 1999 there were more than 30 associations representing over 75 per cent of GPs and an IPA Council was formed, which became the negotiating body for the majority of IPAs in the 1999 contracting round. (Middleton, Dunn, O'Loughlin, & Cumming, 2018, p.17)

In 2010, IPAC and the General Practice Nursing Alliance merged into a new entity, General Practice New Zealand (GPNZ). GPNZ identify themselves as the representative body for general practice: "We provide a strong national voice, advocating for primary care and the health and wellbeing of New Zealanders by supporting the delivery of high-quality general practice services" (GPNZ, 2020). In this way, the legacy of the IPAs continues to the present day.

At the same time as IPAs were coming to dominate the PHC landscape, a much smaller number of community owned and managed primary care organisations (PCOs) were establishing themselves, primarily, in areas of high social deprivation. Malcolm et al. (1999) contrast the governance of these community managed PCOs with general practices noting,

"their governance arrangements give primacy to patients and consumers" (p.24). Common forms of these organisations were community health centres (which were primarily set up and supported by trade unions), and Māori and Pacific health providers (Crampton & Starfield, 2004). They received less funding than general practices as a result of different funding pathways and consequently relied more on non-sustainable government funding, community-sourced funding and voluntary labour through their communities (Malcolm, Wright, & Barnett, 1999)These organisations later came to be referred to as third-sector organisations and many of them became small PHOs in the 2000s.

In 1994, a large group of third sector primary care organisations formed themselves into a national network called Health Care Aotearoa (HCA). By 1999 it was estimated that HCA member organisations served a population of approximately 100,000 (Malcolm et al., 1999, p.24). Although the members of HCA were serving a much smaller population than the members of the IPAs, they were a very influential presence in PHC in the 1990s. They provided PHC in areas of high social deprivation that had been identified as being under-served by general practices. People in these areas were known to have higher rates of complex and long-term health conditions necessitating longer consultations which the HCA PCOs were more prepared to provide (Malcolm et al., 1999). In contrast, the authors noted "it is increasingly recognised that the general practice consultation of 15 minutes or less provides little time to address the educational needs of many individuals and families. This is particularly so within a fee-for-service payment system" (Malcolm et al., 1999, p.31).

The funding and community context of HCA member organisations meant they tended to employ staff on a salaried basis, and employed a number of practitioners other than GPs, who are the costliest practitioners to employ in PHC. Malcolm et al. (1999) argue that the HCA PCOs employing this larger diversity of practitioners had positive impacts on the care they could provide: they provided a broader range of "new and culturally appropriate support services"; they were better at responding to the high health needs of their patients "through providing comprehensive and integrated care"; they were better at implementing a "team-based approach to primary health care" involving more collaboration amongst broader types of practitioners (p.28). By contrast, the general practice member organisations of IPAs were primarily GP owner-operated solo or group practices, usually employing one or more practice nurses.

6.2.4 Health reforms from 1999–2008

A further round of significant health reforms in the 2000s followed the election in 1999 of the Labour-led coalition government. The newly-elected government rejected the quasi-market stance of the previous government and created a health system built more upon local regional planning and service provision (Ashton & Tenbensel, 2012). A key motivation for change was the recognition that social and economic inequality had worsened across the previous decade (Howden-Chapman, Blakely, Blaiklock, & Kiro, 2000). The changes that ensued were significant and were guided by two new government strategies: the *New Zealand Health Strategy 2000* (King, 2000) and the *Primary Health Care Strategy 2001* (King, 2001). Key to the new health system were DHBs and Primary Health Organisations (PHOs). The HFA was disestablished with its purchasing role being divided between the new DHBs and the Ministry of Health.

6.2.4.1 The New Zealand Health Strategy 2000

Two significant components of the New Zealand Health Strategy (NZHS) were the re-shaping of funding and service provision through the new entities DHBs and the re-organisation of PHC through the development of PHOs. Although the roles of the DHBs have remained mostly unchanged since their formation, there was an increased expectation later that DHBs would work more with each other on regional planning across districts following the implementation of the government's BSMC policy (see Section 6.2.5). Nevertheless, the direction set by the NZHS has remained the same.

Cumming (2011) argues that one key purpose of the NZHS was to improve care integration in terms of increasing coordination and collaboration, often justified through the language of improving efficiency of service provision. References to these ideas can be seen throughout the strategy, for example:

> The quality of health services needs to be continually monitored and improved. Services must be co-ordinated, and providers must collaborate to ensure institutional boundaries do not compromise quality of care. Inefficiency means there are fewer health services available for each dollar spent. (King, 2000, p.9)

In addition to this identification of co-ordination between provider organisations, the NZHS also lays out expectations of increased coordination between different types of practitioners and in this sense is seen by some authors as a response to the dominance of medicine in health (Ashton & Tenbensel, 2012; Gauld, 2008).

> A wide range of providers deliver PHC, including general practitioners, nurses, health educators, counsellors, Māori health providers and Pacific health providers. To achieve the aims of the Strategy, it will be important to increase co-ordination between these providers and between PHC providers and public health, and secondary services providers. (King, 2000, p.20)

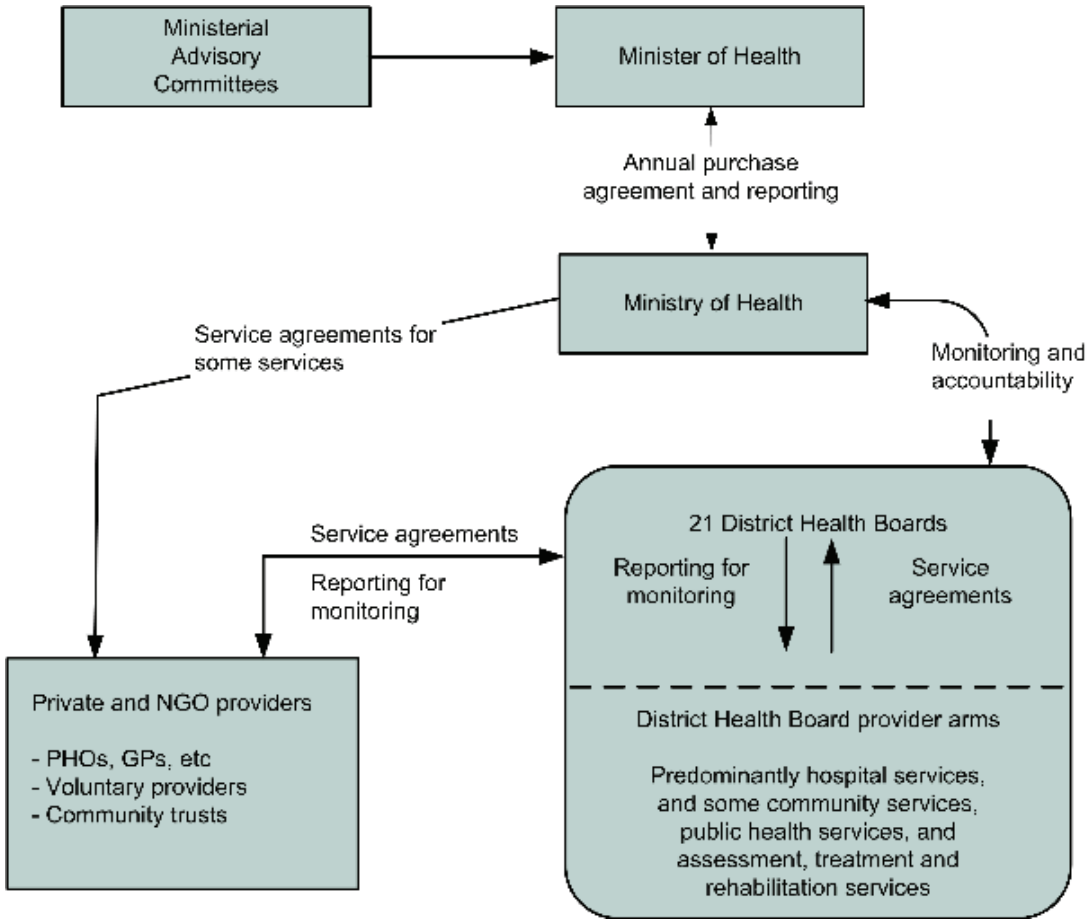
Gauld (2008) notes that the NZHS has been widely supported by the Aotearoa/New Zealand health sector, including GPs, because of its broad focus on population health and attending to the social determinants of health. A particular concern over many decades of both health professionals and policy makers was Māori health inequalities. Attention to this concern in the vision of PHC outlined in NZHS was clear:

> An increase in the number and variety of Māori primary health care providers and the emergence of Māori development organisations are essential components of an effective primary care sector. Priority will be given to ensuring existing successful Māori providers are consolidated and developed. This will ensure that options and choices become a reality for Māori and that issues such as equitable access begin to be addressed. (King, 2000, p.20)

Certainly, the NZHS laid clear groundwork for the PHC Strategy which was released one year later and discussed in Section 6.2.4.2.

Figure 7

The structure of New Zealand's health system, 2008



Note. This figure was produced by Quin in 2009 for the Parliamentary Library and demonstrates the relationships between the DHBs and PHC providers. Copyright 2009 by NZ Parliamentary Library.

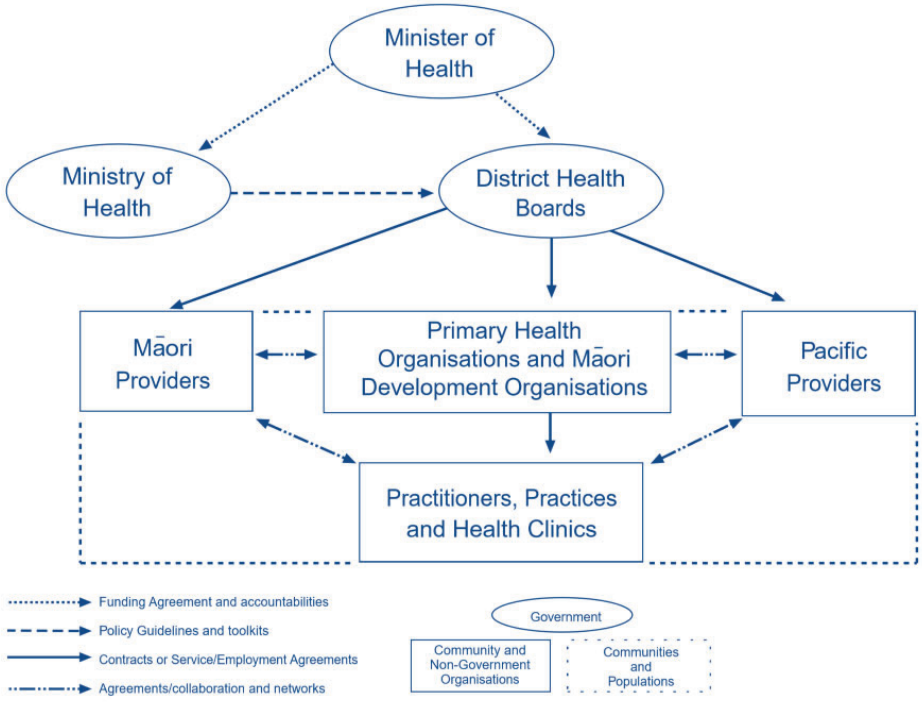
There are currently 20 DHBs across Aotearoa/New Zealand which operate in geographically defined regions, each responsible for planning and funding health services in their districts. DHBs directly provide secondary and tertiary health care services both within publicly funded hospitals, but also in community sites. One of their specific objectives is identified as "promoting the integration of health services, especially primary and secondary care services" (Ministry of Health, 2020a). To fulfil their objectives, in addition to being a direct health care provider, they also contract with private for-profit and not-for-profit organisations to provide a range of PHC and other community services.

6.2.4.2 Envisioned changes to PHC

The PHC Strategy was released one year after the NZHS, in 2001, and described a vision where "people will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care" (King, 2001, p.vii). The themes of co-ordination and collaboration identified in the NZHS translated across into the PHC Strategy with clear expectations on the place of PHOs in contributing to these goals. The PHOs were established as not-for-profit PHC organisations to implement this vision. The government also implemented a significant change to the funding of PHC at this time, shifting to capitation-based funding to PHOs based on their enrolled patients (discussed later in more detail in Section 6.3).

Figure 8

Envisioned relationships between providers in the 2001 PHC Strategy (King, 2001, p.5)



The primary purpose of PHOs, as outlined in the PHC Strategy, was to establish strong agreements, collaborations and networks of PHC providers to serve the PHC needs of their local communities (King, 2001). The PHCS lays out an expectation of different professionals (commonly named as doctors, nurses, community health workers and others) working together to coordinate care. This is especially clearly laid out in the section entitled 'Co-ordinate Care Across Service Areas' (pp.18–21). The term collaboration appears more

rarely in the PHC Strategy, and is used to describe the relationships between providers. (King, 2001).

Though GPs are important practitioners who are given a prominent place in the PHC Strategy, the place of other practitioners is also named throughout. Certainly, the place of nurses working across a diverse range of PHC organisations had begun to be important in the 1990s and was strengthened through the early 2000s (Ministry of Health, 2005). However, the roles of other professionals are also named. In the foreword to the Strategy the Minister of Health laid out the following vision: "Doctors, nurses, community health workers and others in primary health care will work together to reduce health inequalities and to address the causes of poor health status" (King, 2001, p.iii).

Though IPAs had become a significant part of the primary care landscape in the 1990s, the PHC Strategy made no mention of them. In contrast to the private for-profit general practices represented by IPAs, the vision of PHOs was they would be more like HCA organisations; that is, PHOs would be community-based non-profit organisations staffed by multi-disciplinary teams of practitioners (Gauld, 2008). Indeed Gauld (2008) argues that an important aspect of the PHC Strategy was to reduce the power and place of GPs and general practices, in essence re-directing PHC away from profit-making general practices to the not-for-profit sector.

As described in Section 6.2.3, a number of non-profit community-governed health providers emerged in the 1990s that provided care separate from general practices. The PHC Strategy envisioned that PHOs would develop relationships with these providers as well as with general practices to serve the PHC needs of the local communities of the PHO. These relationships were named as contracting or other forms of agreements, collaborations or networks.

It was common for these organisations to employ a wider range of practitioners than general practices including: doctors, nurses, community health workers, kaiāwhina, and a range of allied health professionals (Ministry of Health, 2004). Most of these organisations were set up as charitable trusts and many were established under the umbrella of churches or unions (e.g. the Newtown Union Health Service in Wellington). Other non-profit community-governed organisations are Māori providers with many of these established in the 1990s: for example, Turuki Health Care (which was established in 1995) is one of these

providers in Auckland and offers a comprehensive range of PHC and social services to around 26,000 people (Turuki Health Care, 2021).

A particular form of Māori health provider are iwi providers. These organisations were set up by tribal authorities to provide services for people in their tribal districts. In addition to being strengthened over time by implementation of the government's Whanau Ora programme (see Section 6.2.5) these organisations are increasingly able to access funds made available to iwi as a part of historic Treaty of Waitangi settlements with the Crown. In addition to the above, large city centres which have significant Pacific or refugee/migrant communities commonly also have community-governed providers focused on meeting their needs. The nature and operation of these non-profit community-governed health providers is different to that of general practices in several important ways, including in their funding and in being less GP-centric.

6.2.4.3 The enduring legacy of primary medical care

In spite of the government's "unwritten intention to replace IPAs with PHOs" (Gauld, 2008, p.105) the strength and presence of the IPAs persisted.

> IPAs typically became partners in, or established themselves as PHOs, but many also retained a separate identity, providing management services to the PHOs (for example, negotiating contracts, allocating funding, supporting general practices as businesses, and establishing specialised services to work across general practices).

Certainly, in the early stages of implementing the new capitation funding systems for PHC, the IPAs exerted some influence. One example of this is explained by Carryer et al. (2014) who note that the IPAs were concerned that the way funding was being developed would mean people living with LTCs would not be funded sufficiently. This lobbying resulted in the development of the additional Care Plus funding stream described in Section 6.3.

The ongoing presence of IPAs can be seen in Table 8 (drawing on Gauld, 2008) showing the relationships between these IPA and HCA organisations and the PHOs which formed in the early 2000s. Approximately 80 PHOs were established across the country in the early 2000s. These mostly remained in place until the implementation of BSMC initiatives in 2009/2010 (discussed further in Section 6.2.5), when the number of PHOs fell to 30.

Table 8

Development of PHOs from IPAs and community organisations

Groups of PHO by origin	Coverage of population	Nature of the PHOs
13 PHOs formed from HCA organisations (e.g. Newtown Union Health Service in Wellington)	Serving approx. 5%	Varied in size and shape Operate in areas of high social deprivation, charge low or no patient co-payments
35 PHOs strongly associated with IPAs	Serving approx. 61%	Mostly the IPAs remained the main organisational and service delivery infrastructure Primarily are the larger PHOs (e.g. ProCare)
18 PHOs not originating with HCA/IPA but have contracts with IPAs	Serving approx. 6%	Contract their management services from IPAs
15 PHOs formed independently of HCA/IPAs	Serving approx. 23%	Varied size and shape and connections to other organisations

Note. This overview is summarised from Gauld (2008).

The ongoing influence of the IPAs served to strengthen the place of general practices in the new PHC infrastructure which has continued to this day (Gauld et al., 2019). This continued dominance of general practice in PHC service provision is visible in the current description of PHOs on the Ministry of Health website: "Primary health organisations (PHOs) ensure the provision of essential PHC services, mostly through general practices, to people who are enrolled with the PHO" (Ministry of Health, 2020b).

There are approximately 1,000 general practices across Aotearoa/New Zealand (Downs, 2017). Most are privately owned and GP-operated small businesses (Ashton & Tenbensel, 2012; Gauld et al., 2019). Almost all general practices have an agreement with a specific PHO in order to access a range of government funding distributed by the PHOs (Crampton, Davis, & Lay-Yee, 2005) which is discussed further in Section 6.3.

Although approximately 72% of general practices are owned by one or more GPs, recent analysis of general practice ownership shows this situation is in a state of flux (Thomas, 2018). Approximately 8% of general practices are either fully, or partially, corporate-owned; Additionally, eight of the 30 PHOs have themselves become owners of some general practices (Thomas, 2018). Corporate ownership can be seen to strengthen the profit motivation of general practice operations which stands against one of the key intents

of the PHC Strategy to re-direct PHC provision away from profit-making organisations (Ashton & Tenbensel, 2012).

Much of the funding for non-profit community-governed PHC organisations is often provided through contestable annual contracts with multiple government agencies, for example, the Ministry of Health, the Ministry of Social Development and Te Puni Kokiri (the Ministry of Māori Development). Additionally, these organisations can often obtain funding for short-term contracts directly from DHBs, PHOs, or other community-focused funding sources. These multiple funding sources create many administrative and management burdens for these organisations in terms of petitioning for funds, contract negotiation and management, as well as ongoing reporting requirements to multiple funders. This funding environment creates much uncertainty for the future of staff, and interventions within these organisations.

In addition to these differences in funding, these non-profit community-governed PHC providers often have a stronger focus on working with the social determinants of health (Crampton, Dowell, & Woodward, 2001; Crampton et al., 2005). Commonly, these organisations are focused on addressing Māori health inequities. Indeed, Crampton and Starfield (2004) have noted that, "Government is using the non-profit sector to address long-standing unmet needs of the indigenous population in response to historical and contemporary injustices and government's obligation to Māori under the Treaty of Waitangi" (p.3).

In spite of the potential of the 2001 PHC Strategy, by the latter part of the 2000s concerns remained that very little had changed in terms of how PHC services were provided. General practices still dominated PHC service provision and there remained difficulties with care coordination with other services, particularly with these non-profit community-governed providers. This provided a context for further change with the change of government at the end of 2008.

6.2.5 A refocus of PHC priorities between 2008 and 2017

A change of government at the end of 2008 heralded further changes to PHC with the incoming National Party-led government implementing the health policy they had campaigned on, *Better, Sooner, More Convenient* (BSMC) which was intended to support better integration of primary care services that were delivered "closer to home" (Ryall, 2007) The main organisational infrastructure of DHBs and PHOs remained in place and a desire for

health care coordination continued to be a focus: "the new policy direction for health creates an environment where health professionals in the community are actively encouraged to work with one another, and with hospital-based clinicians to deliver health care in a co-ordinated and co-operative manner" (Ministry of Health, 2011a, p.3). Additionally, BSMC reinforced the focus on local access to PHC that had already been expressed in the PHC Strategy 2001.

However, BSMC also paved the way for a re-focus of PHC service delivery under the banner of "new models of care" (Ministry of Health, 2011a). They began this process late in 2009 through a contestable funding 'Expression of Interest' (EOI) process. Organisations were invited to submit EOI as consortia and demonstrate their capacity to meet some of the following expectations of BSMC: increased coordination of services for people with LTC; more collaborative working relationships between a wider range of health professionals; and the establishment of "co-located, multi-disciplinary primary-health-care provision through integrated family health centres (IFHCs)" (Ministry of Health, 2011b). Given the strong connections between these expectations of the EOI and the focus of this study on ICP, consideration was paid to these alliances in the development of my methodology and recruitment. This resulted in recruiting participants from one of the IFHC that was set up under BSMC at Site One.

Ultimately nine alliances were formed and have continued to operate to this day. The implementation of the contracting with the new health alliances stood alongside the Government's agenda of reducing the number of PHOs across the country as a way to "improve the infrastructure for, and reduce the costs of, primary care service planning" (Cumming, 2011, p.6). Across time, the number of PHOs reduced from 80 in 2010 to 36 by July 2011 (Cumming, 2011), and then fell further to 30 PHOs which have continued to the present day.

Another important initiative of the National Party-led government was the implementation in 2010 of the national Whanau Ora[8] programme, "a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kokiri [the Ministry of Māori Development] and the Ministry of Social Development" (Ministry of Health, 2018). Whanau Ora is focused on improving the wellbeing of individuals in the

[8] The word whānau is a Māori word referring to an extended family group. The word ora refers to life, health and vitality. When not capitalized they are commonly used together (whānau ora) to signify ideas of family health and wellbeing. When capitalized they refer to this government sponsored programme.

context of their families and whanau. The primary focus of the programme is on Māori families, though the providers have always welcomed people from all ethnicities and cultural backgrounds into their services. The programme implements "a joined up approach that focuses on all factors relevant to whānau wellness, including economic, cultural, environmental factors, as well as social factors" (Ministry of Health, 2018).Work carried out under this initiative has consolidated the place of Māori providers in PHC as a consequence of increased funding flows from government to these providers through the Whanau Ora programme.

During 2015 the Ministry of Health consulted on a draft update of the New Zealand Health Strategy. The resultant updated strategy was released in 2016. Downs (2017) argues that the new strategy did not introduce any major policy shifts but did reinforce the following key approaches of the Ministry of Health:

> It emphasises supporting person-centred care; shifting care from hospital and specialist centres to community providers; supporting a high performance and cost efficient system; promoting person-centred care through integrating services and strengthening roles of people and whanau; and leveraging technology and greater analytical capabilities. (p.16)

Despite a generally positive reception, some critiques of the revised 2016 strategy have been published. For example, although the rhetoric on addressing health inequities from the previous 2000 strategy remains in the 2016 strategy, Came, McCreanor, Doole and Rawson (2016) note their ongoing concern that system change to address inequities "relies on the isolated efforts of committed individuals and organisations to achieve health equity and Te Tiriti engagement, rather than through a planned systems viewpoint" (p.72).

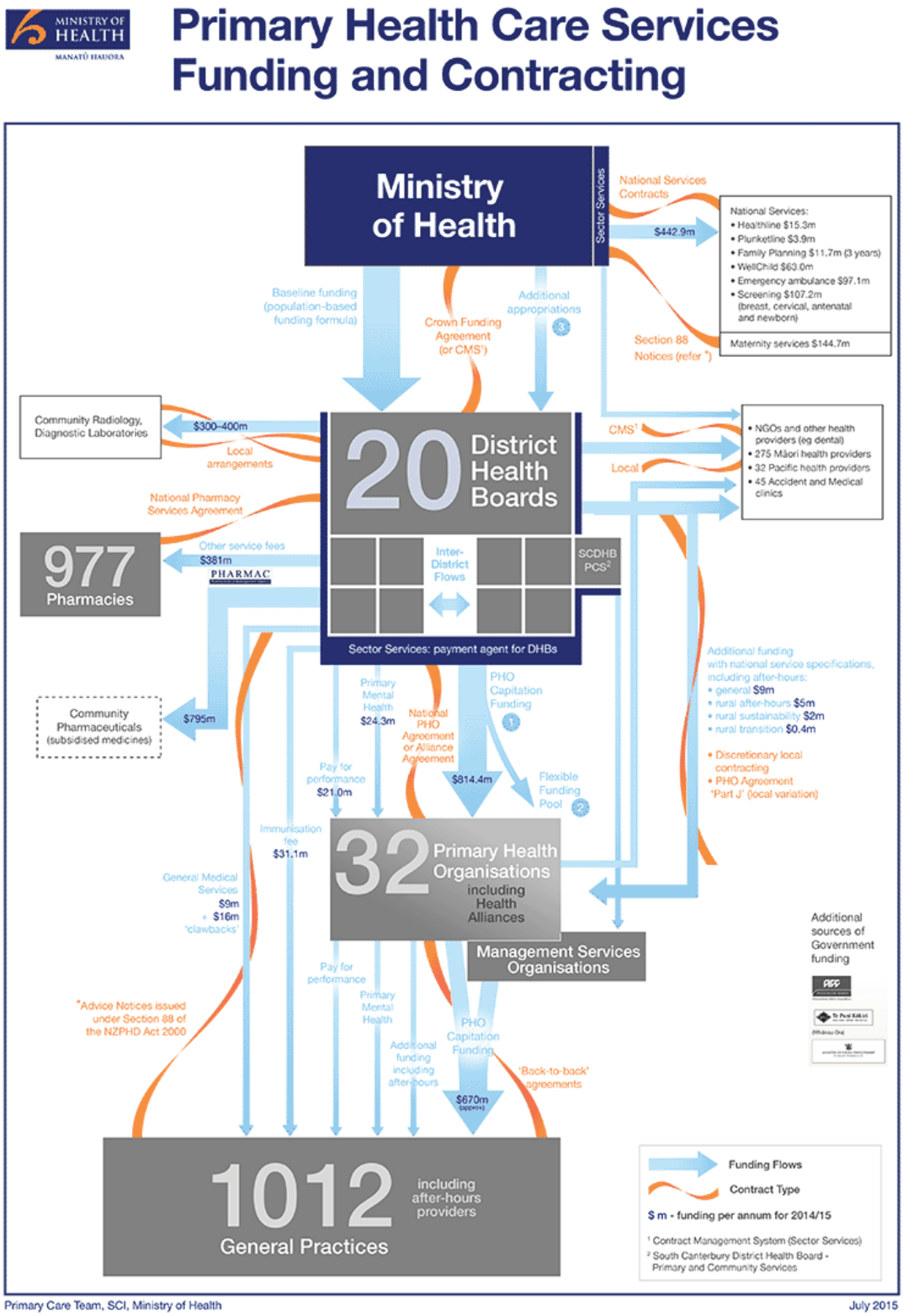
6.3 Funding of PHC

In Aotearoa/New Zealand health and disability services are largely publicly funded through taxation and Accident Compensation Corporation levies. The Ministry of Health (MoH) is responsible for allocating most of these public funds with health and disability services being delivered through a variety of public, private and non-governmental organisations. More than three-quarters of this funding is allocated to DHBs who are responsible for planning, delivering and contracting health care services in their regions (Cumming et al., 2014). In this section I particularly focus upon the PHC funding that the DHBs allocate to different parts of the health system.

The implementation of the 2001 PHC Strategy replaced the previous GMS subsidy paid to GPs with weighted capitation payments paid to PHOs for their enrolled patients. Downs (2017) explains that the rationale for moving to capitation funding was this "would incentivise delivery system reforms to improve access and address historic disparities in health outcomes" (p.5). The way that this new funding system was implemented has led to funding and contracting of PHC becoming incredibly complex, as is visible in Figure 9. At the same time as this complexity has developed, Gauld (2008) argues, the system has increasingly come to strengthen the dominance of PC at the expense of PHC in this country. In this section I will discuss some of this complexity, as well as some of the ways that PC has been strengthened through these systems. All figures used in this section, unless stated otherwise, refer to summary data for the 2014/15 funding cycle (Ministry of Health, 2015).

Figure 9

An overview of the funding and contracting of PHC services



6.3.1 MoH's direct funding of some national PHC services

In addition to funding DHBs to commission and provide PHC services, the MoH has a range of direct contracts for national PHC services which include family planning, maternity services and health screening programmes. Additionally, there are national service contracts for several telephone-based advisory health services (e.g. Healthline and Plunketline) for the public to access free health advice. The MoH also contract with some PHC non-governmental organisations, including Pacific and Māori providers. In 2015/16 Māori providers received $94.7 million via direct contracts with the MoH (Ministry of Health, 2017a). The most significant PHC funding from the MoH, however, is that provided to DHBs.

6.3.2 DHB funding of PHC

Funding to DHBs is calculated on a population-based funding formula (PBFF) which was re-introduced with the establishment of DHBs in 2001. The PBFF is weighted according to different health service usage by different population groups in the district according to a range of factors including: age, gender, ethnicity and levels of social deprivation (Cumming et al., 2014). DHBs contract with a range of providers in their districts to provide PHC. In addition to the particularly significant contracts for PHC with PHOs (discussed in Section 6.3.3) DHBs also contract with community radiology, diagnostic laboratories and with the Pharmaceutical Management Agency (commonly known as PHARMAC[9]) for pharmaceuticals. In a similar fashion to the MoH, DHBs also fund some PHC non-governmental organisations, including Māori providers. In 2015/16 Māori providers received $175.6 million from DHBs (Ministry of Health, 2017a).

6.3.3 DHB funding of PHOs

The main DHB funding of PHC is directed to PHOs primarily via the National PHO Agreement (for PHO funding) or Alliance Agreement (for Alliance funding) (Ministry of Health, 2015). A significant portion of this PHC funding of PHOs is in the form of capitation-based payments based on the number of people enrolled in the PHO (Ministry of Health, 2015). Enrolments in the PHO are established through people completing and signing a form at the general practice they attend. Each capitation payment is weighted according to a number of criteria including: age, gender and ethnicity of enrolees; levels of

[9] PHARMAC is a government agency established under an Act of Parliament within the New Zealand health system. Its role is to make funding decisions on medicines and medical devices to ensure the best possible health outcomes for New Zealanders.

social deprivation; and the numbers of people who are high users of PHC services (Cumming et al., 2014). Though capitation payments are calculated on the criteria of individuals, the funding is pooled and does not flow to the individual.

In 2014/15 PHO capitation funding amounted to $814.4 million dollars (Ministry of Health, 2015). The vast proportion of this capitation funding (approximately 82%) flows directly to general practices with the remainder of the funds used by the PHO for a range of purposes including: funding the Management Services Organisations set up to support the PHOs in general practice administration; and funding specific contracts the PHOs implement to fulfil their obligations to the DHB and government, like general practice after-hours services and preventive health services.

There have been a number of changes to the ways that the capitation fund is calculated over the years with two significant changes being the introduction of the Flexible Funding Pool (FFP) and the Very Low Cost Access (VLCA) scheme. The FFP programme was established in 2013 through the consolidation of three previously separate funding schemes: Health Promotion Services, Services to Improve Access (SIA) and CarePlus. The FFP is additional to the main PHO capitation funding and requires provision of additional information to be supplied by the PHO (which they obtain from the general practices) to secure the funds. The FFP is visible in Figure 9 to the right of the PHO Capitation Funding. In this research study it was the FFP used to fund the PHO initiated community-based care programme at Site Two identified as the Wellbeing Support Team (see Chapter Seven).

Whereas the health promotion funding was designed to enable PHOs to carry out health promotion for all their enrolled members, the other two funds were created to improve access of particular populations to primary care services. CarePlus was designed to support general practices to provide more comprehensive services to patients with high health needs due to their chronic conditions, acute medical needs, acute mental health needs, or terminal illness. It is recognised that these patients require more time with practitioners for longer consultations and more regular reviews of their care (Carryer et al., 2014).

The SIA fund was designed to support PHOs in the development of new services to reduce health inequalities for populations known to have poor health status: Māori, Pacific people, and those living in areas of high social deprivation (Ministry of Health, 2014). To be eligible for SIA the PHO must describe how the service is targeted to one of these groups, how it is to be delivered, and how it will contribute to improved health for the targeted

population. The MoH states the SIA is not to be used to reduce user co-payments, but rather to support development of "a multi-disciplinary approach to improving access to health care through the establishment of district alliances to coordinate the provision of health services between secondary, primary and community-based services" (Ministry of Health, 2014). This intent particularly aligns with the PHO community-based care programme at Site Two discussed further in Chapter Seven.

Additional funding for general practices is available from the government through the Very Low Cost Access Scheme (VLCA) which was introduced in 2006. Participating general practices have access to increased capitation payments. Three of the four general practices in this study accessed funding through the VCLA scheme (General Practice Four was the only exception). To be eligible for this funding a general practice is required to have an enrolled population of 50% or more of high needs patients (Ministry of Health, 2020c). These are people who are defined as Māori, Pacific or living in areas of high socioeconomic deprivation. Access to the scheme requires the general practice to keep its co-payment fees within the following parameters: zero fees for children 0-12 years old; $13 maximum fees for children 14-17 years old; $19.50 maximum fee for adults 18 years and over (Ministry of Health, 2020c). Approximately a third of general practices are VLCA practices (Ministry of Health, 2020c).

6.4 Other sources of income for general practices

In addition to the PHO capitation funding, general practices also receive other funding. Some of this funding is also directed through the PHO (like 'pay for performance' and 'primary mental health'), whereas other funding flows directly from the DHB (like 'immunisation fee' and the General Medical Services). Of particular significance across the history of PHC in this country, however, are the out-of-pocket payments made by patients at the time of care. The origin of these was described in Section 6.2.1. These out-of-pocket payments make up approximately 10.5% of health expenditure (Cumming et al., 2014, p.77).

The amount of the out-of-pocket payment varies according to the age of the patient and they type of funding the general practice receives via the PHO (e.g. whether the general practice is a VLCA practice). Typically this amount is the difference between the fee set by the GP (operating as a private business) and the amount of the government subsidy they are eligible for. They are highly variable across the country and can be up to $75 for a 15-minute appointment. The government has set up a range of schemes to subsidise out-of-

pocket payments including: Community Service Cards, High Use Health Cards and Pharmaceutical Subsidy Cards (Cumming et al., 2014).

Out-of-pocket payments have been noted to play an important part in patients not seeking care, in spite of concerted efforts of successive governments in limiting or reducing the amount of these payments. Downs (2017) reports that 28.8% of New Zealand adults reported they did not get needed primary care services in the previous twelve months in 2015/16; further, 14% of adults describe cost in seeing the GP as the main reason for not seeking care (p.20). Although there are a number of aspects that contribute to this poor access, Downs (2017) offers a particular criticism of the VLCA scheme because it does not fulfil its intent of targeting the people who are most in need: "Only 56 percent of high-needs patients were enrolled in VLCA practices while 44 per cent were not. Of the 1.3 million New Zealanders enrolled in VLCA practices 44 per cent did not meet the definition of high needs" (Downs, 2017, p.36).

Funding and contracting of PHC services in Aotearoa/New Zealand is complex (Fancourt, Turner, Asher, & Dowell, 2010). While the intention of the 2001 Primary Health Care Strategy was that PHOs would act as the key coordinating bodies for PHC, a number of funding avenues remained, and further pathways added, which undermined the potential influence on PHC that PHOs could exert. In short, the vison of the PHC Strategy has not been adequately supported by the ways that PHC is funded (Gauld, 2013).

6.5 The primary health care workforce

Following the health reforms of the 2000s, concerns grew regarding the stressors upon the health workforce and its future capacity. These concerns resulted in a series of taskforce reviews leading ultimately to the establishment of the government business unit *Health Workforce New Zealand* (HWFNZ) in 2009. HWFNZ published a series of reports in the following years which documented concerns, particularly the mismatch between health workforce demand and supply (Ministry of Health, 2016). These HWFNZ reports have been complemented with reports from professional bodies including the Nursing Council of New Zealand (NCNZ) and the Medical Council of New Zealand (MCNZ) on their own nursing and medicine workforces (Medical Council of New Zealand, 2019; Nursing Council of New Zealand, 2019). These reports have signalled ongoing concerns about the age demographic of the medical and nursing health workforces noting the unsustainability of the current health

system if changes are not made. Key aspects of these concerns are outlined in this section, noting that an increased focus on ICP is argued as a solution to these concerns.

The health workforce concerns do not appear to have improved since the 2000s. The recent report from the Health and Disability Review (2020) comments, "from a workforce point of view staff are feeling more and more stressed, facing increasing demands and significant shortages in supply, and the public hear more about deficits than they do good news stories" (p.3). Nearly all health professions are needing to deal with adjustments to the scope of their work with the introduction of new roles, new technologies and changing models of care. Meanwhile, the increasing incidence of LTCs which it has been shown are best dealt with by the PHC system are putting stress on health systems (Ministry of Health, 2016). As noted in Sections 6.2.4.3 and 6.3.3, general practices continue to hold central place in PHC in Aotearoa/New Zealand, despite the expectation of changing models of care and increased roles of other professionals (Downs, 2017). Attention below, thus, focuses initially on GPs and the practice nurses who work within general practices.

There have been concerns expressed for a number of years that the medical workforce in Aotearoa/New Zealand, in line with international trends, is ageing. In 2015 more than 40% of doctors were aged 50 years or over (Ministry of Health, 2016). Within the vocational scope of general practice, concerns are greater. Of the vocational scopes which have more than 100 members, general practice has the third highest average age of doctors at 53 years (Medical Council of New Zealand, 2019, p.20). Although general practice remains the medicine vocational scope with the largest number of members (with 3,671 doctors in 2019), there is concern that the overall proportion of specialists who are GPs has been decreasing as this is down from 37% of all specialists in 2000 to 28% of all specialists in 2018 (Medical Council of New Zealand, 2019, p.17).

The importance of nursing was clearly signalled in the 2001 PHC Strategy: "primary health care nursing will be crucial to the implementation of the Strategy" (King, 2001, p.23). Difficulties in realising this vision have been noted along the way. In 2005 Kent, Horsburgh, Lay-Yee, Davis and Pearson (2005) noted in the Ministry of Health's National Primary Medical Care Survey that "establishing a career path and appropriate education standards for nurses are challenges for the primary health care workforce that must be addressed if nursing is to maximise its contribution" (Kent et al., 2005, p.viii).

Ultimately, by 2019 the NZNC notes that the second largest portion of the nursing workforce (15%) was located in employment settings they identify as Primary Health Care and Community Care (Nursing Council of New Zealand, 2019, p.5). Within this broader category is the group of nurses identified as practice nurses who work within general practices. The practice nurse role was developed in the 1970s when GPs first became able to access government funding to employ nurses under the Practice Nurse Subsidy Scheme to assist them in their general practice (Hart, 1980). Now there are a similar number of practice nurses to GPs within each general practice: In 2019 there were 2,927 practice nurses (Nursing Council of New Zealand, 2019, p.39), that is, a ratio of 0.8:1 practice nurses to GPs. There are similar concerns to the GP workforce about the ageing of practice nurses, with 46.4% of practice nurses in 2019 being aged 50 years and over (Nursing Council of New Zealand, 2019, p.39).

Another important scope of nursing practice identified as a part of the PHC reforms of the early 2000s was that of nurse practitioner. The role was established in this country in 2001 as a pathway for experienced registered nurses to continue to advance their knowledge and practice to the highest level of clinical expertise in nursing. The Ministry of Health envisioned the nurse practitioner to be an important addition to the PHC workforce. They released a key resource, *Nurse Practitioners in New Zealand,* in 2002 to provide DHBs with the latest international research on nurse practitioners to support them to establish this new nursing workforce (Ministry of Health, 2002).

In spite of the Government's envisioned contributions of nurse practitioners to PHC, the number of nurse practitioners has grown slowly over the past two decades with 365 on the register at 31st March, 2019 (Nursing Council of New Zealand, 2019). They work in a range of practice areas with the most common being identified as PHC where 137 (38%) nurse practitioners work (Nursing Council of New Zealand, 2019, p.25). Downs (2017) calculated that nurse practitioners comprise 3% of the GP workforce and that this is much lower than expected compared to other countries: She notes for example that in the United States nurse practitioners comprise 27% of the GP workforce (p.44).

The nursing workforce contributes more widely to PHC in many roles outside of general practices, for example in non-profit community-governed primary health providers as described in Sections 6.2.3 and 6.2.4. In addition to more traditional nursing roles, sometimes these nurses are employed in care co-ordination or patient navigator roles. These kinds of roles have mainly been developed to assist patients with LTCs to navigate their care

from different practitioners, who often work for different providers. Similarly, some PHOs in Aotearoa/New Zealand have established health coaching and self-management support roles to also work with patients with LTCs. It is common for nurses to work in these roles, although as noted below, sometimes these roles are filled by people who do not have a professional qualification but are highly qualified to work with their own communities like kaiāwhina.

The PHC Strategy articulated a clear vision that PHC would become more than the provision of services by general practices that are staffed by GPs and practice nurses: "no single practitioner or type of practitioner can meet people's needs completely. A range of practitioners with the skills to communicate and collaborate in the patient's interest are needed" (King, 2001, p.18). The intent was that this wider range of practitioners would help to re-focus PHC away from treating individuals with disease towards improving, maintaining and restoring the health of people in communities (King, 2001, p.6). Although GPs and nurses continue to dominate PHC, there are a small number of other professions that are commonly identified as sitting alongside general practice and nursing in PHC. The profession of pharmacy is particularly significant, though social work, podiatry and physiotherapy were also visible in the sites of PHC researched in this study.

Pharmacists are one of the specific professional groups that were named in the 2001 PHC Strategy and are highly visible in relation to primary care provision across Aotearoa/New Zealand. In 2019 there were 3,832 practising pharmacists registered (Pharmacy Council, 2019). The interdependence of pharmacies and general practices is built into the health system through legal, professional and funding mechanisms, with a central consideration being that doctors are not able to dispense medicines. Instead, doctors write prescriptions that are dispensed by pharmacists, a process that strengthens relationships between general practices and pharmacies.

Similarly to general practices, community pharmacies operate as for-profit organisations established on commercial principles, thus they pay close attention to income-generating and cost-reducing activities. Yet, at the same time, pharmacies are situated within community contexts and recognise their responsibilities to provide care to people in their communities. I note also that some pharmacies operate more exclusively as medication dispensaries and so the commercial aspects of selling products can be less important to their core modus operandi. The interplay between these simultaneous accountabilities (business imperatives and community care responsibilities) is discussed in Chapter Nine.

Community based podiatrists and physiotherapists, like pharmacists, most commonly work within small for-profit organisations in community settings. These organisations often develop strong relationships with general practices as referrals from general practices provide an important income source. There were 430 registered podiatrists in 2019 with 80% of these operating in private practice (Carroll, Jepson, Molyneux, & Brenton-Rule, 2020). In contrast to the small number of podiatrists, there are a large number of physiotherapists, 4,391 in 2020 (Physiotherapy New Zealand, 2020). It was estimated 59% of physiotherapists worked in private practice in 2018 (Reid & Dixon, 2018). In this study, at Site One, General Practice Two is an IFHC which is co-owned by a GP and physiotherapist and has a business arrangement with a podiatrist who operates a podiatry clinic within their premises.

In this study, two of the general practices at Site One jointly employed a social worker to work with them. Although data is scarce on the place of social workers in PHC, it appears this is quite rare. There were 6,333 annual practising certificates issued by the Social Worker Registration Board (SWRB) for 2019/20 (Social Workers Registration Board, 2020)[10]. Employers of the largest numbers of social workers are known to be DHBs (19%) and Oranga Tamariki/Ministry for Children (22%) (Social Workers Registration Board, 2020). Even though the SWRB identifies 29% of social workers are employed by non-Governmental organisations (2020), it is unclear how many of these work in PHC settings.

In spite of the likely low numbers of social workers in PHC settings, there are strong connections between the profession of social work and the Alma-Ata-inspired 2001 PHC Strategy. Certainly, several authors have argued that the profession of social work aligns strongly with the setting of PHC (Döbl & Ross, 2016; Foster & Beddoe, 2012; Tadic, Ashcroft, Brown, & Dahrouge, 2020).

6.5.1 The non-regulated workforce

In addition to health professionals in PHC, two other groups of practitioners that are not a part of the regulated workforce have been shown to be important: community health workers and general practice receptionists. The people historically referred to as community health workers now tend to be collectively referred to as kaiāwhina and are recognised as a significant workforce in PHC. Although workforce data is scarce for this group, it is

[10] Social work registration in Aotearoa/New Zealand does not provide a clear picture of social worker numbers as registration has been voluntary throughout the history of the profession in this country (this changes on the 31st March, 2021). An associated confounding factor is that social workers are often employed under varied job titles that do not necessarily include the title social worker (e.g. a health services coordinator, or an advisor).

becoming clearer that they will be an increasingly important group required to respond to new models of care and support in the health system in response to LTCs (Ministry of Health, 2016). They tend not to have professional health qualifications but rather are recruited for their abilities to meaningfully engage with communities that health providers wish to work with. One of the participants in this study is employed as a kaiāwhina by the PHO in Site Two.

Recent research has also identified the important place of the general practice receptionist in the provision of primary care (Neuwelt, Kearns, & Browne, 2015; Neuwelt, Kearns, & Cairns, 2016). The receptionist is usually the first person that people make contact with when visiting a general practice. Receptionists commonly have relationships with patients that span many years and may even know several generations of families that use the general practice. Neuwelt et al. (2016) have argued that the roles of general practice receptionists are complex and have been insufficiently researched as they have a service role which is oriented towards the needs of both the practice and patients. This means receptionists often end up in complex situations with conflicting responsibilities.

One aspect of this complexity in their role relates to their physical position in the general practice: "Their location at the front of the practice means that the receptionists are well placed to witness the gaps between what patients need and ask for, and what the practice is able to provide" (Neuwelt et al., 2016, p.127). Neuwelt et al. (2016) argue that the receptionist then commonly undertakes *care work* to address this gap which can entail "providing reassurance to anxious or distressed patients" (p.127). They argue this is especially important given the vulnerability of many people visiting general practices. In Chapters Seven, Eight and Nine this place of the general practice receptionist in interprofessional collaborative practice is explored.

6.6 Ongoing struggles with ICP in the PHC system

The vision of the 2001 PHC strategy to create a cohesive PHC system where each DHB would fund a PHO via capitation funding to provide coordinated care for their communities was never realised. By 2008 the system was described instead as "a labyrinthine funding and organisational system with a variable capacity to deliver on the government's reform objectives" (Gauld, 2008, p.93). In spite of various efforts to streamline processes and organisational arrangements, ten years later Downs (2017) notes that "some DHBs are working with up to five different PHOs and some PHOs are working

with up to four DHBs" (p.37). These ongoing complexities with funding and organisational systems between DHBs and PHOs are likely to impact on ICP with the system being described as fragmented and difficult for users to navigate. Cumming (2011) explains:

> Fragmentation arises because service users receive care from a wide range of professionals working in a large number of provider organisations, while a lack of information sharing and liaison between these professionals and provider organisations is seen to result in poorly co-ordinated care. (Cumming, 2011, p.1)

One difficulty in implementing the PHC Strategy has been identified as general practices remaining the main organisation infrastructure for the delivery of PHC instead of realising the potential for PHOs to do so. Gauld (2018) argues this creates problems with being able to achieve the vision of the PHC Strategy as the main professional group that dominates general practices is general practitioners (GPs), supported by practice nurses. In spite of the government's intention to subsume GPs into the PHO infrastructure, the implementation of the PHC Strategy has allowed general practices to maintain their dominance. Gauld (2008) notes this is a pattern seen in other parts of the world: "Around the world, the traditional power of the medical profession has been eroded, yet doctors continue to be a force in the policy process because of their special capacity to determine the policy agenda" (p.110).

A further difficulty with implementation of ICP in PHC is the status of the PHC workforce with a need to strengthen and broaden this workforce being identified. The recent Health and Disability System Review (2020) clearly signals a need for changes to the way we provide care and how the health care workforce is used. The authors conclude:

> Workforce development is a key constraint in our current health and disability system. In line with worldwide trends New Zealand is experiencing growing clinical workforce shortages. Our system will not be sustainable unless we change models of care and use the workforce differently. (Health and Disability System Review, 2020, p.7)

Challenges to the numbers of doctors and nurses have been outlined, however, an ongoing issue identified by Downs (2017) is that insufficient attention has been paid to supporting nurse practitioners as alternative providers to GPs. Downs (2017) has argued that better co-ordinated primary care results from widening the multi-disciplinary team in PHC settings, and that having more nurse practitioners working alongside GPs is one way to do this that has been shown to be successful in other countries: "Instead of focusing on expanding care provided by GPs, some positions, such as nurse practitioners, can take on

functions previously performed by doctors. Nurse practitioners can also serve as alternative providers to GPs" (p.39).

6.7 Conclusion

Despite numerous attempts to re-organise the funding and organisational infrastructure of PHC to move further towards the Alma-Ata inspired PHC Strategy 2001, I have shown in this chapter that there remain many concerns which indicate potential for ICP is not built into the system. Primary medical care endures and is supported by the ongoing centrality of general practices in our PHC system. These difficulties are not unique to Aotearoa/New Zealand. The OECD (2019) argues PHC across OECD countries is failing to achieve its full potential and identifies three contributing factors: that PHC physicians are "not doing enough preventive medicine, or not co-ordinating care" (p.26); "the lack of resources in PHC relative to other sectors" (p.26); and "that the organisational model of PHC still mostly relies on face-to-face consultations with a physician who works in a solo practice" (p.27). The OECD goes on to argue that inclusion of other health professionals within the PHC organisational model, better teamwork with these professionals and better integration of care across the health and social service sector is required to enable PHC to realise its potential. In the following three chapters (Chapters Seven, Eight and Nine) analysis will show the extent to which these international concerns are playing out in PHC in this country and how this is impacting upon ICP.

Chapter 7 – A narrative analysis of the practices of interprofessional collaboration and reflection

7.1 Introduction

In Chapter Five I described Keller's (2013) sociology of knowledge approach to discourse analysis and the way this approach draws on a range of different frames to structure analysis of text. This chapter is focused on the narrative analysis frame of this approach and examines the stories that PHC practitioners told me when I asked them questions about their understanding of ICP and RP. Narratives consist of a group of events, or episodes, occurring in some form of storyline sequence involving social actors in particular settings (Keller, 2013). The analysis I have adopted in this thesis focuses upon connections between these narratives and the discourses associated with interprofessional collaborative practice and RP. The narrative analysis of this chapter is, thus, used alongside the analysis of space and place in Chapter Eight, to inform the discourse analysis of Chapter Ten. Four main narratives were identified for analysis:

1. A pharmacist's relationships with two general practices
2. The PHC work of an iwi provider
3. A community-based team provide PHC services
4. The re-organisation of PHC in a small provincial town.

Narratives One and Two are located within Site One and Narratives Three and Four are located within Site Two. There are no relationships between the PHOs, DHBs and iwi providers in the two different study sites.

Reflecting Keller's approach, analysis is structured consistently beginning with a rationale of why key aspects of the episodes were chosen which make up the narrative. The key narrators and their main roles are then introduced in an overview of the storylines which hold together their actions. Analysis then considers the important objects which lay at the centre of interactions, the metaphors utilised in the narratives, and the values conveyed through the interactions of the social actors when engaging with the key objects. Considerations of values drew upon Padaki's (2000) definition of a value as, "a relatively

enduring behaviour pattern (would/would not, willing/unwilling, readiness/hesitation, etc.). A value represents an organisation of attitudes" (p.422).

7.2 Narrative One – A pharmacist's relationships with two general practices

7.2.1 Key aspects of selected episodes

This assemblage of episodes is situated in Site One and focuses on ICP between a pharmacist and practitioners working in two different general practices situated close to this pharmacy. One of the general practices identifies itself as an integrated family health centre (IFHC) and the other as a Medical Centre. Across the 20 interviews in this study there were many stories told about the important relationships between pharmacists and other people in the PHC system. The particular episodes in this assemblage were chosen as they provide a representative account of many of the features of these relationships.

The pharmacy and the Medical Centre are members of a nation-wide chain of pharmacies, general practices and other health care providers. The pharmacy and the Medical Centre are within sight of each other across a car park which supports a small suburban shopping centre in the provincial town where they are located. The IFHC is several blocks away and is located within a small collection of shops close to a major intersection, a marae and several schools. Though there is another, much smaller, pharmacy located in this same small collection of shops, this smaller pharmacy does not feature significantly in the episodes of this assemblage.

7.2.2 Storyline overview

The first set of episodes describe the ways that the pharmacist, John, and the staff of the Medical Centre, moved past difficulties to develop stronger collaborative relationships. In one of these episodes, John describes the historical context of him being unsuccessful in his efforts to build a stronger collaborative relationship with the Medical Centre. His motivation for this stronger relationship was wanting to improve the practices of writing prescriptions within the Medical Centre and also to be able to quickly resolve issues that commonly arise with prescriptions such as unclear information, or errors relating to drug names or dosage.

Table 9

Key narrators of Narrative One

Key narrators	Contextual notes
John – Pharmacist	Key protagonist at the centre of the relationships in the first series of episodes; key supporter of the implementation of the gout project
Mary – Practice manager at the medical centre	Led the moves to resolve the working and relationships difficulties in the first series of episodes
Tina – Nurse clinical leader in the medical centre	Provides insight into the difficulties and the interpersonal processes associated with accepting John as a collaborative peer in the fortnightly team meetings of the medical centre
Denise – Social worker in the medical centre	Described John's presence at the Medical Centre, and at team meetings

There had been a recent breakthrough in this relationship which is described in these episodes by John, as well as by two staff within the Medical Centre: Mary the practice manager and Tina, the nurse clinical leader. Episodes were selected for analysis which described how the players moved through this crisis and ultimately established strong collaborative relationships with John being invited to regularly attend the newly established fortnightly team meetings of the medical centre.

The second set of episodes in this narrative involves a number of the same narrators and is focused on the implementation of a gout pilot project in the district. This project was a response to the high incidence of gout in the local population and the commitment of a range of practitioners to improve care to this group and improve the way that gout is managed in their community. The gout project was initiated by a GP with the support of the PHO following a professional development seminar where a GP academic presented findings of a study about better ways of managing gout in PHC involving coordinated activity between multiple practitioners.

People with gout who met the project criteria were enrolled onto the 13-week project by a GP and had structured access to the pharmacist and an arthritis educator. The key organisations involved in the gout project were these: several general practices (including the Medical Centre and the IFHC of these episodes), several pharmacies, the PHO and the Arthritis Foundation. For John, the gout project is significant because it created easy, structured opportunities to have ongoing communication with GPs, to connect patients with general practices, and to have meaningful engagements with people visiting the pharmacy.

Other social actors (also participants in the study) had lesser roles in the narrative. These people were either mentioned by John, Mary or Tina as a part of the narrative, and/or made comments themselves about key events which were included in analysis.

Table 10

Other key social actors

Other narrators	Contextual notes
Lisa – GP at IFHC	Named John's importance in interprofessional and inter-organisational collaborative practice in their community and with IFHC
Josie – Practice nurse at IFHC	Described the importance of relationships between pharmacists and the IFHC and referred to John
Christine – Pharmacist in the block of shops close to the IFHC	Described the importance of relationships between pharmacists and the IFHC and referred to John

The objects, metaphors and values identified through analysis of Narrative One are summarised in Table 11 and discussed in the following sections.

Table 11

Objects, metaphors and values of Narrative One

Objects	Script
	Lab test Form
	Gout Project
Metaphors	Reflective practice as problem solving
	A seamless patient experience
	Spending time and making time
	Putting out fires and stopping fires happening
	Opening the door between the general practice and the pharmacy
Values	Operating as a business
	Being patient-focused
	Job satisfaction
	Sharing information to provide better care
	Reflecting is integral to practice

7.2.3 Objects

Analysis of Narrative One identified objects, metaphors and values which are summarised in Table 11. There are four main objects which lie at the centre of the

interactions in these episodes on interprofessional collaboration: *the script*; *the lab test form*; and *the gout project* itself. The paper script (an abbreviated reference to the prescription[11]) is a significant object which sits at the centre of a number of episodes. In the first set of episodes in this assemblage much of the action is based on the pharmacist, John, engaging with the Medical Centre about these paper scripts.

A range of issues or questions arise for pharmacists with scripts. Typically, these include areas of the script that are illegible, unclear, erroneous, or which refer to medication or dosage which has changed on PHARMAC listings. These issues and questions necessitate pharmacists engaging with GPs to seek clarification. John often found it quite difficult to contact GPs to resolve these issues. Sometimes practice nurses act as an intermediary between him and GPs. In the first set of episodes, these difficulties in communicating with GPs are what leads John to keep returning to the Medical Centre to attempt face-to-face engagement. In one particular week of frequent visits leading to tensions, Mary initiated contact with John to resolve these tensions. Tina, and Denise, at the Medical Centre both talk about the significance of interactions between the pharmacy and the Medical Centre regarding scripts.

In the second set of episodes the lab test form was the object in focus in the interpersonal interactions associated with the gout project. The lab test form is a document completed by a GP instructing the contracted laboratory testing provider in the region to carry out particular tests to inform clinical decision-making. In the gout project it was a requirement for people to return to the pharmacist at five points over 13 weeks to pick up their medication (in the form of blister packs) and to be given their lab test form to take to the lab. John observed that interactions with participants over the lab test forms established a structured space for him to have regular health education conversations. This enabled him to reinforce key messages about managing their gout, including the importance of going to the laboratory to get the tests done. The lab test form also acted as a further mechanism to keep communication channels open between John and GPs.

The gout project is itself a key object in these episodes. John describes it as significant in supporting the establishment of stronger communication channels between his pharmacy and local general practices. One of the GPs confirmed the significance of the gout

[11] The prescription is a document that is written by a health care practitioner (typically a doctor or nurse practitioner) which sanctions a person with the correct legal authority (e.g. a pharmacist) to provide medication. The prescription also contains instructions on how to take the medicine (e.g. dosage; frequency; duration).

project in consolidating communication with the pharmacist. For John, the gout project enabled him to have particular conversations with people enrolled on the project that would have been more difficult otherwise; Similarly, John suggests it created opportunities to engage with people not enrolled on the project but would benefit from it.

> *Whenever anyone's coming in for a gout flare-up over the counter type meds, we're spending a bit of time with them talking about that, and saying "oh no, are you happy enough for us to-- who's your GP?" and they tell us who it is, and we go "well are you happy for us to send a note through to them to talk about perhaps getting you on the gout programme?" and-- so that's been really positive.*

John reported that the gout project had also contributed positively to his relationships with other pharmacists, who can often be in a competitive relationship due to the business model within which they operate.

> *I've been over at IFHC, if I'm over at the shops over there, I'll call in and have a chat to Christine and see how she's going with the gout patients and see if she's got any, 'cos I'm sort of the pharmacy contact for that…so, you know you use that just to see how she's going and any other questions and queries about things. So we've developed more of a relationship over-- in the last sort of seven or eight weeks.*

As John reflected on this growing relationship with Christine he had a reflective moment thinking about the collaborative working relationship between Christine, himself and the IFHC. At that stage John had already developed a strong collaborative working relationship with the IFHC and was attending their Friday weekly doctors' meeting to discuss patients they had in common. Christine was not attending these meetings.

> *I mean it would be nice to actually both be there at the same time. I'm not quite sure why that's not happening, that may be something I have a wee chat about. Cos then we can discuss patients and that together which would be quite interesting. I might actually mention that.*

7.2.4 Metaphors

As the narrators reflected upon their collaborative and reflective practices, they drew on a range of metaphors to illustrate their meaning. Five of them explored in this analysis are the following: RP as problem solving; providing a seamless experience for the patient; spending time and making time; putting out fires and stopping fires happening; and finally improving collaborative practices by opening the door between the general practice and the pharmacy. In the first set of episodes, Mary, described her motivation in solving the

communication problems between the pharmacy and the Medical Centre as a "common sense" way of ensuring there was a *seamless experience for the patient, a notion she returned to* on a number of occasions, as in this statement:

> *It's about problem solving; What's working? What are the barriers that are getting in the way of actually getting what the patient needs out of this. So for me it's around-- I mean obviously there's some efficiencies that need to happen from their* [the pharmacies] *perspective and our perspective, but at the end of the day our driver should be that actually we're making it seamless for the patient. And for me, if we keep that as foremost and focus of what we are trying to do, generally there's a solution somewhere.*

This idea of improving inter-organisation communication so as to improve the experience for patients was also a part of John's focus. In the years prior to Mary taking over the management of the Medical Centre, John reports he had asked the previous manager whether there were meetings at the Medical Centre he could attend to discuss issues with scripts and improve what was happening for patients. He had been told there were no such meetings: "Oh no, the doctors only meet, and it's all to do with running the business rather than patient orientated" (John). This was a source of frustration for John who named the importance of *spending time* on these kinds of interactions with the staff in general practices so as to *reduce time wastage* and thus provide better patient care.

John used this metaphor of spending time to make things better in a number of ways. He particularly named the importance of spending time with people visiting the pharmacy, and spending time with practitioners in other organisations, like general practices, hospital-based services, and the PHO. John sees a direct relationship between spending time with general practices to improve prescription writing and him being able to spend time with patients in his pharmacy:

> *If they get it right at their end it just means at our end its less stressful, and the patient's not inconvenienced. So what we're trying to do there is we're just trying to improve the streamlining. What that does for <u>us</u>, is it means that you've got more time to spend with our patients without being under stress.*

On several occasions, as John refers to his efforts resolving script issues with general practices, he uses the phrase *putting out fires*:

> *We know there's not enough doctors, and nurses and pharmacists and techs to do the work. But if we're not running around putting out fires because things aren't done properly, we'll have a lot more time to spend with our patients.*

In addition to increasing the amount of time he spends with patients, John also sees other benefits from participating in regular meetings at general practices. These he variously describes as *reducing time wastage*, and also *saving time*. However, John also sees benefits to the level of care that general practices themselves provide as a consequence of this time that he spends with them:

> *They'll be asking questions that are not patient specific but it's about what treatments are available, or, what's funded, what's not, what can we do in this situation? So giving them general information so as they can help their patients um, improve their health by some means or another.*

Another metaphor used in common by John and Mary was that of *opening the closed door between the general practice and the pharmacy*. In the first set of episodes in this narrative, John noted "we went around the back door and came in rather than banging on the front door". With the appointment of Mary as practice manager John notes "the doors are a lot more open now." Similarly, Mary describes the process of allowing John to attend the fortnightly team meetings: "we sort of just opened the door" (Mary). With regard to the PHO and the gout project John recalls "beating at the door to start the project."

The fortnightly team meeting at the Medical Centre was an initiative established by Mary when she became practice manager, prior to any involvement by John. Both Mary and Tina tell stories which link this team meeting to increasingly collaborative relationships between GPs, practice nurses and administration staff within the Medical Centre. Later, this fortnightly team meeting became key in consolidating the collaborative relationships between staff within the Medical Centre and John. Attending the fortnightly meetings, John reports, resulted in better collaborative relationships overall.

> *When we have issues with patients that we're not sorting out by faxes or phone calls we'll go over and sit down with the… practice nurse or the doctor and sit down one-on-one and say, "Hey this is not happening, lets-- can we do something with this? This guy would-- can we get some more bloods here?" or something like that, and they're quite open to that now.*

John's relationships with the IFHC have been in place for longer than those with the Medical Centre. Although the IFHC does not have a multi-disciplinary meeting like the Medical Centre, it does have a weekly doctors' meeting which John has been attending for some time. This has developed a strong sense of trust between John and the doctors resulting in a different way of managing script issues:

We know kind of what they mean, and we just alter it here, and we go back once a week to sort it out, so unless it's a major error, or major query, we're perhaps not contacting them as much, cos we've got more of an understanding.

7.2.5 Values

Both John and Mary value the importance of focusing their work on the patient and their needs. Increased cross-organisation communication contributes significantly: "I would expect that it's a given that we have these relationships, actually that we're all critical and part of the same picture, and if we're patient-focused that should be happening" (Mary). At the same time, they also acknowledge the presence of competing aims, as a consequence of the business model of their operations:

> *One of the biggest things, are the contracts and the funding mechanisms that sit behind it, because as much as we would like to be all things to all people, we have restraints and restrictions about what we can, from a business model perspective, where we can start and stop and where we can be a part of that.* (Mary)

John, similarly, describes the importance of these financial imperatives to his business, yet, identifies two sets of activities that are in tension with him spending time on making money to "pay the bills." The first of these time-consuming activities that does not connect to the business model is spending time with "high needs" people who are visiting his pharmacy, particularly people with LTC. One way John makes sense of this tension is by talking about job satisfaction.

> *It just gives me a buzz when I can work with other people and just get an end result that-- for me personally, it's more job satisfaction really, and just getting a good end result or getting-- just seeing something happen, or start the process and something to change to happen to just improve things.*

The second area John spoke about is investing time in conversations with doctors and nurses in general practices, so as to make things better in the future.

> *You can save more time by having those conversations, one-on-one directly, and having that, than trying to put out the fires when things go wrong further down the track. So at the end of the day, it is a financial plus, but there's no way of measuring that to any great extent.*

Visible in the analysis of the episodes for both John and Mary is the importance they place on critically reflecting on what is currently happening with regard to the practices of PHC around them. Here, John describes one process they implement within the pharmacy:

> *We've got a little book in the dispensary for these practice meetings, little points that come up, something crops up and you write it down. And there's columns and whoever goes to whichever practice on whatever date, just so as we can tick it and date it, so as we know when we've actually talked to the practice about certain things.*

These kinds of processes develop relationships between John and the local general practices which the implementation of the gout project built upon.

Mary similarly is constantly tracking what can be better about the way the Medical Centre operates and commonly utilised the language of quality improvement in her stories. Mary explains her motivation for this stance: "it comes from a desire to actually put aside the barriers and work towards a goal of actually achieving what's important for the patient."

This has led to Mary working hard to change the culture of the fortnightly team meeting at the Medical Centre:

> *Just taking a step back from the day-to-day stuff, to consider whether there's different ways of doing it, or a better way of doing it, or what worked well, and what didn't work well. To create a sense of satisfaction on what you're doing*.

Mary and John both recognise that their internal organisation-based information technology systems are not enabling them to provide the seamless care they desire. They both saw value in John having access to parts of the medical records as a way to increase communication flow related to script errors. However, they both perceive obstacles in their respective systems and potential ethical troubles preventing them implementing this.

Strengthening working relationships across organisational boundaries led to the narrators valuing what other providers offered. This took time. The clinical nurse leader, Tina, described needing to get over her sub-conscious defensiveness in seeing John as an outsider who was suddenly present in 'their' meeting. It was not until she encountered John in another context – a local community meeting – where she suddenly felt more able to "actually listen to what he was saying" (Tina). She thinks this was because "he wasn't in my patch" (Tina), and she realised that "oh! You've got a lot to offer" (Tina). This shift in stance, and the consequent building of the relationship over time was an important feature of the consolidation of the collaborative practice relationships between the pharmacist and the Medical Centre. As summarised by Mary, "just a recognition and acknowledgement of where you all sit in that, that actually you're all part of the bigger picture to be there for the patient."

7.3 Narrative Two – The PHC work of an iwi provider

7.3.1 Key aspects of selected episodes

The assemblage of episodes comprising this narrative examines some of the collaborative practices in the PHC work undertaken by staff of an iwi provider located in Site One. The staff of this iwi provider work across a large district demarcated by historically defined tribal boundaries. This area encompasses that of the providers identified in Narrative One. The work of the iwi provider is commonly situated in places like community centres, schools and marae, rather than traditional general practice rooms where GPs and practice nurses are mainly located.

The narrators also talk about the PHC work they carry out in people's homes. One significant aspect of the work of the iwi provider is described as making connections between the people they work with and other parts of our health and social service infrastructure like community-based supports and organisations, pharmacies, general practices where people are enrolled, and other parts of the health system. Oftentimes this is to provide comprehensive care for people, though in the case of general practices, this is also related to re-connecting people with the PHC provider with whom they are enrolled due to funding processes. In Chapter Six it was noted that the primary funding for PHC flows from the Ministry of Health to DHBs to PHOs to general practices. An important mechanism to calculate this funding is enrolment of the patient, primarily with a general practice. If an iwi provider is a part of a PHO then they do get funded for patients enrolled with them, however, this is not possible when people are already enrolled with a general practice as the long-term funding remains with the general practice.

7.3.2 Storyline overview

The two main narrators in these episodes are a nurse practitioner, Martha, and a GP, Kevin. Neither of them identify as Māori. Both reflect continuously on how their experiences of providing health care in the iwi provider contrast markedly with their experiences of working in other contexts.

Table 12

Main narrators of Narrative Two

Narrators	Contextual notes
Martha – A nurse practitioner	Martha initiates collaborative activity with multiple practitioners from various organisations. She commonly re-connects people/patients with the general practices they are enrolled with, but from whom they have become estranged. She runs nurse-led clinics in different locations.
Kevin – A GP	Kevin is the clinical manager of the iwi provider and narrates stories about how practitioners (including Martha) work with each other, the people who use their services, and with other organisations. He contrasts the PHC activities of an iwi provider with a traditional general practice.

Martha was the first nurse practitioner employed in this organisation and describes the time and energy she has put into establishing nurse practitioner-led activities in their organisation and across the communities they work in. This included educating pharmacists, GPs and practice nurses about the role of a nurse practitioner. She also describes a number of her struggles to make connections between the people that they encounter within the iwi-provider who most need services, and other parts of the health system, particularly general practices.

The objects, metaphors and values identified through analysis of Narrative Two are summarised in Table 13 and discussed in the following sections.

Table 13

Objects, metaphors and values of Narrative Two

Objects	Flu shot/jab TestSafe Notes 10-minute time slots Photo and Signature PDRP Portfolio
Metaphors	Time scarcity: making time; investing in time General practice ownership of patients Service delivery Barriers to healthcare
Values	Weaving people back into PHC Recognising the humanity of the people they work with Valuing the skills/knowledge of other practitioners Reflecting improves practice

7.3.3 Objects

There are six main objects which are central to ICP and RP in the episodes of this narrative: *the flu shot* (a.k.a. *the flu jab*) which is Martha's naming of the influenza vaccination; *TestSafe*[12] an online clinical information sharing service; *the notes* which Martha writes about her patient care; *the 10-minute time slots* of appointments people have with GPs; *the photo and signature on a piece of paper* used by Martha to let practitioners in her community know who she is and begin educating people about the role of the nurse practitioner; and *the PDRP*[13] *portfolio* in which nurses document their practice and reflections on their practice.

7.3.3.1 Flu shot (a.k.a. flu jab)

Martha tells a number of stories about how she uses the flu jab as a form of engagement with people who have become disconnected from PHC service provision, particularly from their general practice. Additionally, the flu jab is sometimes used as a mechanism to build stronger interprofessional collaborative relationships with the practitioners, particularly practice nurses, within general practices. For example, in one story Martha is speaking to a GP as a part of her ongoing work at building relationships between the iwi provider and the general practice:

> [Martha asks] *"Do you have any patients who live at home, who are unable to get to the practice for their flu shot that you would like us to go and see?" So then she'll hand that over to the practice nurse who'll say, "oh, I haven't anyone for a flu shot, but they could go and see Mrs So and So and check her, because we haven't seen her for ages."*
>
> *We go into the pharmacy, and the pharmacist will say, "oh, Mrs So and So? She hasn't picked up her medication for weeks." And I go, "okay, where does she live?", and I go and pop round and see if they're okay.* (Martha)

In these instances, Martha then returns to the general practice and provides an update on what she has found. Mostly these updates are provided to practice nurses (as GPs are too

[12] TestSafe is an online clinical information sharing service where results from DHB facilities, community laboratories, community radiology providers and community pharmacists are stored and can be accessed by a range of health providers like general practices and iwi providers (http://www.careconnect.co.nz/testsafe).
[13] The Professional Development and Recognition Programmes (PDRP) are administered by the Nursing Council of New Zealand http://www.nursingcouncil.org.nz/Nurses/PDRPs.

difficult to meet with), and they are commonly in the form of consultation notes (Section 7.3.3.3).

At other times, Martha is working with a person who has been disengaged from PHC and uses the flu jab as a means to prolong contact with them during a home visit. In this way she is able to spend more time to build a stronger relationship and explore their PHC needs. Martha then develops and implements a care plan. She concludes by documenting the interactions in consultation notes and sending these to the person's general practice. Both of these instances describe work for which the iwi provider is not funded.

7.3.3.2 TestSafe

Martha talks passionately about the ways that the on-line platform TestSafe helps her carry out her roles, including the ways it contributes to interprofessional collaborative practice: "I love TestSafe, I love TestSafe, I can't tell you how much I love TestSafe." She describes how she uses TestSafe to track what medications people are taking. She can also determine what care people have received in different parts of the health system and who has provided that care. For example, Martha describes a situation where someone arrives at the clinic and wants more medication but cannot name what pills they are taking: "I go into TestSafe, load in their NHI[14] and it'll tell me exactly what tablet they're taking, who prescribed it, when their last pick up was, and the pharmacist."

Martha identifies TestSafe as especially important as she is often working with people who have become estranged from their general practice, and who commonly could not recall what general practice they were enrolled with. Martha relays a number of stories where TestSafe assists her in identifying their general practice, thus enabling Martha to communicate with the practitioners at the general practice, and also to reconnect these people back into their care. Before TestSafe, Martha relied on the following process to identify which general practice people were enrolled in:

> *I would phone the general practice and "I've got this patient here, are they one of yours?" And if they don't know I phone the PHO and say to the PHO, "Can you put me through to the IT chap? Right, I've got a patient here, here's the NHI number, can you tell me who their GP is?"* (Martha)

[14] National Health Index (NHI) number: "The NHI number is a unique number that is assigned to each person using health and disability support services. The NHI is an index of information associated with that unique number." https://www.health.govt.nz/our-work/health-identity/national-health-index/nhi-information-health-consumers/national-health-index-questions-and-answers.

Martha also credits TestSafe as contributing to better clinical practice explaining that prior to TestSafe "you're fumbling around in the dark and you're more likely to make a clinical mistake. And that's not good for the patient when they really need to have the best service."

7.3.3.3 The notes

Martha describes the importance of documenting what happens in her delivery of services and refers to this as "writing notes", or "writing in the notes". Once she identifies what general practice people belong to, she sends them these notes. She describes two motivations for sending the notes: a requirement of good clinical practice; and a way to contribute to the ongoing relationship between the iwi provider and general practices. However, in several episodes Martha expresses frustration that the general practices do not seem to be interested in what she has been doing with their patients:

> *I've been there* [to her home]*, and I've assessed her, and I've done some brief intervention, and I've written the notes, and I've sent the notes to the GP. But the GP has no inclination to sit down and listen to me rabbit on about his patient.* (Martha)

Instead, Martha has a sense that her consultation notes appear to just become another unread part of the patient's file.

7.3.3.4 Ten-minute time slots

Time is named as a significant object by both Martha and Kevin and they make a number of references to the 10-minute time slot in relation to ICP and RP. They identify it as constraining and limiting. When asked what gets in the way of ICP and RP within the general practice, Kevin reflects:

> *I think it's time, I think it's always time, especially in general practice. You know GPs are incredibly busy. They are seeing people, you know, every 10 to 15 minutes. So actually taking them out of that consultation process and doing something else requires a huge shift.*

Kevin explains that these 10 to 15 minute time limits are a result of funding mechanisms: "If they're not seeing people they're not generating income, that's the major failing I see with our model that we've got. It's all based around consultations, kind of face-to-face reactive consultations, there's very little about being pro-active". This connection

between the 10-minute time slot, the funding infrastructure and the ways practitioners carry out their work is especially visible when contrasting the general practice with the iwi provider. Martha explains:

> *The GPs who have businesses … they have 10-minute time slots, because that's what they've calculated their business costs on. You can't reflect, you can't spend time with your patients. And it's been really interesting working in a Māori health provider where we have open clinics, where we can take as long as we like, and where we can see patients with multiple issues and address many of them in one sitting.*

7.3.3.5 Photo and signature

In addition to the objects outlined above which featured across several episodes, Martha's stories featured objects that were significant to individual episodes of interprofessional collaborative practice. One significant example is Martha's use of her *photo and signature on a piece of paper* to facilitate engagement with every pharmacy in the town where she practices. Martha described a multi-pronged rationale for this process.

Martha believed that pharmacists in the district did not have a good understanding of the role of the nurse practitioner as there were so few of them in the country. She anticipated possible difficulties in pharmacists dispensing medicines for prescriptions that she would write and wanted to engineer a situation where she could engage in educating the pharmacists on the nurse practitioner role, in particular their authority to prescribe. Martha wanted to ensure the pharmacists understood this authority and had a chance to connect her face and identify the person behind the name and signature on future prescriptions they would see.

At the same time, Martha also wanted to build a strong collaborative relationship with each pharmacist knowing that this relationship would be essential to deal with the complexities she anticipated would arise in her work. Martha was conscious that the clients of the iwi provider commonly have multiple complex health needs and are living in areas of high social deprivation. She also knew that many of these people were disengaged from their general practices and that she would likely be their most direct access to medication. Yet, these same people commonly struggle to pay part-charges on medication. Conversely, Martha is able to use the 'local knowledge' of the pharmacist to help 'find' people who have become estranged from PHC.

7.3.3.6 PDRP Portfolio

Martha referred to the PDRP portfolio a number of times as she talked about the importance of reflection. This portfolio is a document that all nurses registered with the Nursing Council of New Zealand (NCNZ), including practice nurses, clinical nurse specialists and nurse practitioners, are required to compile across a three-year cycle. It comprises evidence of their practice and their reflections on this practice. NCNZ use the PDRP as part of their recertification of practitioners.

Martha refers to the PDRP Portfolio several times in reference to her own reflections on practice and also in a story where she is supporting another nurse to reflect on her practice. Martha recognises two important aspects of the PDRP Portfolio. First, she notes "I have to demonstrate to Nursing Council and nursing leaders, different areas, that I am who I am and I'm a leader, and I'm this, that and the other, because that's the level that I'm working at as a nurse practitioner" (Martha). Second, Martha explains how the portfolio enables her "to justify who I am to the patient":

> *You have to always remember that you have to have a knowledge base that is up to date and evidence based. Otherwise how can you say to a patient, "I'm a professional, trust me." They have to be able to feel confident that what you're delivering is the best possible treatment.*

7.3.4 Metaphors

Four important groups of metaphors were visible: *time* was named as a scarce and contested resource; patients were named as being *owned by general practices*. Metaphors of *service delivery* were used to describe health care; finally, Martha and Kevin used metaphors of *barriers* when describing people's struggles to get the health care they needed.

7.3.4.1 Time scarcity

Both Martha and Kevin talk about time as a scarce commodity in PHC which limits what can be done. They use terms like *spending time*, *investing time* and *making time*. For example Kevin comments, "the 10-minute consultation limits the capacity for GPs to invest the time to think about and develop their ideas of PHC and to consider working in different ways".

Sometimes Martha and Kevin talk about "spending time", indicating an investment of a scarce resource. For example, Kevin talks about his use of whanaungatanga[15] at the beginning of clinical consultations: "I would spend, yeah a good 10 minutes, five minutes sometimes, depending how things go just trying to make connections, and linkages, and exploring who their whanau is and so on" (Kevin). Both Martha and Kevin identify having more time for important activities, like building relationships, within the iwi provider than they had when they worked within a general practice.

7.3.4.2 General practice ownership of patients

In several episodes Martha expresses frustration in the way that patients are seen as "belonging to" or being "owned" by a general practice. Martha sees this sense of patient ownership by general practices as interfering with ICP as it leads to practitioners within the general practice being reluctant to share information with practitioners who work in places like iwi providers: "They won't tell you anything and that's not helpful. It's not helpful to the person, and terribly frustrating for us when we are trying to do the best that we can for the individual". Martha's investment of time in building relationships with general practices is an important strategy to get around this reluctance.

7.3.4.3 PHC is service delivery

Martha frequently uses the notion of *service delivery* to refer to the health care she provides. She talks about care as a "package", "a service", "an intervention" or "support" with the processes of providing this care being named as "delivery". She names the people working in health care as "providers" of services, and sometimes personifies the organisations themselves using phrases like "services seeing a patient". Here, Martha defines her understanding of interprofessional collaborative practice using this notion of service delivery:

> *Collaborative practice for me is the delivery of a health service or health intervention using a multidisciplinary approach that incorporates not just nursing but social needs, emotional needs, psychological needs and tapping into services that can support those aspects depending on what arises from an assessment.*

[15] Whanaungatanga translates as relationship or kinship. It connotes a sense of relationships that are developed through shared experiences and working together which provides people with a sense of belonging (Moorfield, 1990).

Kevin uses different language to Martha, referring instead to "seeing people" and "solving problems". Here Kevin uses these terms to argue for a team approach:

> *We are seeing high needs people, they have complex problems - often social problems - best not dealt with by a doctor, but best dealt with by a team of people to work together and try and solve problems.*

Nevertheless, a connection to service delivery is still visible in Kevin's deliberate utilisation of the term *client* instead of the term patient: "A patient is someone who suffers, that's what the Latin means, it comes from the word *patiens*, to suffer" (Kevin). Kevin believes utilising the term *client* helps to shift the focus towards treating them as people. This idea is explored further below in the section on values.

7.3.4.4 Barriers to PHC

Martha and Kevin often referred to the people they work with as being disengaged from their general practice commonly using the language of barriers patients encounter.

> *Patients who have run up a bill with their general practice, patients who feel uncomfortable with the receptionist or the doctor or whatever. Patients who can't afford the fees, patients who can't get there cos of transport, lots of different barriers.* (Martha)

As Kevin provides further examples of these barriers he reports people commonly saying "they felt like the doctor wasn't talking to them properly, he wasn't listening to them. Sometimes there's even, they've felt like they've been overtly discriminated against in a racist way".

7.3.5 Values

Four different values which are held by Martha and Kevin are described: the caring of those who are disconnected from the PHC system; recognising the humanity and the whanau of the people they work with; valuing of the skills/knowledge of other practitioners (beyond doctors); and reflection improves practice. They identify these values as strongly connected to working within the iwi provider context.

7.3.5.1 Caring for those disconnected from PHC

Martha and Kevin note that the care process in a general practice is almost always initiated by individuals in a community, who identify having a health need. The individual

then contacts the general practice to make an appointment in response to this need – typically expecting this appointment to be with a GP. In contrast, the iwi provider runs a more open clinic system in community localities that does not require individuals to phone to make an appointment. Many of these clinics are run by nurses, and there is not necessarily a GP present. It is common at these clinics for people to arrive with their whanau:

> *For example, in our community centre there's a big area which people sit in. Only half of them will be people waiting to see me, the other half will just be people off the street who are just coming in to have a chat, or supporting their whanau member.* (Kevin)

Martha and Kevin recognise many people who have health care needs do not seek PHC through general practices. They believe practitioners need to explore alternate mechanisms of engagement with those people, instead of assuming that if people need care, they will seek it out. It is this value which underpins much of their work including the operation of clinics within community localities, and going to people's homes to provide care. In carrying out their work, they recognise that people encounter barriers to PHC and as practitioners they have a responsibility to support people to move past these barriers. Examples of this are described in Sections 7.3.4.3 and 7.3.4.4.

Martha and Kevin are conscious that operating from within the iwi provider means they do not receive funding for delivering long term primary care to people who are enrolled elsewhere in a general practice (who do receive that funding whether or not people are utilising the general practice). The difficult and time-consuming work that Martha undertakes in building relationships with general practices (and pharmacies) demonstrates how highly she values re-connecting those people who have become disengaged from PHC, as demonstrated in this dialogue recounted by Martha with a patient and then a practice nurse:

> *"Do you have a doctor?"*
>
> *"No."*
>
> *"Okay, when you did have a doctor where did you go?"*
>
> *"I went to* [name of general practice]*"*
>
> *"Okay, thank you." Phoned up* [name of general practice]. *"Can I speak to the practice nurse?"*

"Sure."

"Have you got Mr Brown registered on your system"

"Oh my God, you've got Mr Brown?"

"Yes, I have."

"We've been looking for him for years."

"Well he's here now and he has a problem with diabetes and he needs a statin and he needs this, and he needs that"

Martha reflected on further details of this case and explained that there were other issues with poor eyesight, broken glasses, and no money. The sight issues meant he had been having trouble carrying out his blood sugar pinprick tests and also had trouble in managing his medication. In this instance the general practice handed over care of the patient to the nurse practitioner.

7.3.5.2 The humanity of the people they work with

Closely intertwined with re-connecting those who have become disengaged from PHC is a valuing of the humanity of the people they provide care to. This value is visible in the stories that both Kevin and Martha told of their personal professional journey from working in other parts of the health system to their current roles within the iwi provider. Kevin recalls becoming more and more conscious over the ten years he worked in a general practice that it was people's social contexts that had the largest impacts on their health: "Those were things that I couldn't deal with. The general practice had GPs and it had nurses, and that was it. So I grew dissatisfied". Kevin contrasts this experience with the way he is able to work within the iwi provider.

They experience something different when they come to our service, they're not-- they're treated as being people, and their whanau's enquired about. And we'd see them, but we'd also see any of their mokos[16] that they've brought in, or whoever, it's not told make another appointment and come back, it's-- people are treated as humans.

[16] Moko is a common abbreviation of the word mokopuna from the Maori language that refers to a child or grandchild. It has been commonly adopted into English usage in Aotearoa/New Zealand and Kevin (GP) uses it here in an English language way adding an 's' to signal the plural.

Kevin believes that the community context of their clinics contributes to this valuing of people and a recognition of the wider family systems that people belong to, describing one clinic held in a primary school where "there'll be kids running around". These kinds of contexts create what Kevin calls a "human" and "community-centric" environment for these kinds of interactions: "We will just have a conversation, 'kia ora, how's it going?' And they'll have a chat about what's happening. So there's all this interpersonal stuff that goes on which I think has an impact".

7.3.5.3 Valuing the skills/knowledge of other practitioners

Kevin places high value on the relationships with other practitioners within the iwi provider. The roles of the doctor, the nurse practitioner and the nurses are important; but Kevin also values other roles within the iwi provider:

> *We have a variety of people in our service, so, different professions, nurse practitioner, community support worker, health navigators. These are all people that conventional general practice doesn't have, and when you have a wide variety of people, it kind of lends itself to kind of more of a collaborative environment.*

This variety of people, Kevin argues, is essential: "So we are seeing high needs people. They have complex problems, often social problems, best not dealt with by a doctor, but best dealt with by a team of people to work together and try and solve problems". The associated collaborative environment within the iwi provider, Kevin argues, is supported by some of the cultural practices in the organisation, as in this normal morning routine:

> *We start off our mornings with just a general get together as a wider team. So it includes just, you know, the clinical team, but also management, and the rheumatic fever team, and the health navigators. We all get together and have a karakia, and a waiata and it kind of like seems to set the tone, I enjoy that.*

Kevin situates himself in the organisation explaining: "It's also less hierarchical as well. So, I'm employed by the organisation, I'm not the owner. I'm not in any position of power, like I'm not the manager. I'm just a doctor that happens to be working there". Kevin places the skills and knowledge he has alongside those of his colleagues and talks about being a member of a team and sharing clients: "If I've got someone that I'm concerned about, then someone else can look after them as well. And they offer a different set of skills than I do".

In the iwi provider, Kevin explains, nurses work much more independently than in general practice: “The nurses take on board a lot more responsibility, will do things on their own without running it past me”. Kevin describes acting as an advisor to the clinical practice of the nurses: “they diagnose and treat, and then what they might do is they might discuss the cases with me if it’s a bit complicated or outside of their area of expertise”. Kevin particularly values the working relationship he has with the nurse practitioner and explains that “she would do as much as a GP”. Kevin sees himself as more of a consultant for her to assist with difficult cases, noting they “problem solve things together” and that their relationship is “more of a collegial kind”.

This valuing of the skills and knowledge of other practitioners also extends beyond the iwi provider and informs Martha’s investment of time with these relationships. Martha argues this necessity, noting “if we didn’t do that no-one would talk to us”. Martha describes three main motivations for this investment of time: it supports the re-connection of people back to their general practice; it pre-empts potential problems in care provision (as in the example of the photo-signature object provided to pharmacists); and it enables better care coordination.

Martha’s efforts at building relationships with practitioners of other providers is not limited to general practices and pharmacies. She also described similar stories of engagement with a medical outreach service of the local public hospital that was working with a patient who had been discharged. In one of these stories Martha noted that she had established a strong working relationship with one of the nurses in this service, whom she refers to as a senior nurse. When this senior nurse knew that a patient of Martha’s was being discharged from the hospital into the community and one of her medical outreach nursing colleagues was going to be working with this patient, she encouraged her colleague to make contact with Martha.

The care coordination became complicated with some changes to the patient’s needs and consequent changes to medication. Martha describes the end of a particularly complex episode where the patient had been attempting to push away the medical outreach nurse:

> *So I said to the patient, “well they need to monitor you, so why don’t I just send a message to* [the medical outreach nurse]*?” So I did, I texted a message to the Medical Outreach, so they know what we’re doing. And I wrote it in his book* [patient’s service record in their home] *as well, in case they go to a home visit and so on. And I copied a prescription, so they’ve got a copy of the*

prescription to stick in their book. So everybody's on the same page and everybody knows what I'm doing. That's collaborative practice. (Martha)

Martha's efforts in establishing a relationship with the service and with individual practitioners were key to this outcome.

7.3.5.4 Reflection improves practice

Both Kevin and Martha talk about the importance they place on reflection and RP in their work. They relate important aspects of their personal professional journeys in their stories about RP. However, they also both describe obstacles and difficulties in being able to reflect as much as they would like. These two aspects are sometimes interwoven in the text.

Martha believes that RP is fundamental to the work of all professionals explaining "you have to reflect on your actions because everything you do have [sic] consequences to another human being". Additionally, Martha identifies RP as "part of the nursing process" and part of ensuring she is able to practice safely and engender trust in the people she works with: "In order for somebody to hear what you're saying and believe what you're telling them you have to develop that trusting relationship. But you also have to reflect on the consequences of your behaviour and actions towards somebody anyway".

Although Kevin declares "GP's don't do reflective practice", he goes on to explain how much he has come to highly value reflection. As he conveys its importance Kevin described a previous supervision/mentoring relationship with a psychologist: "That was a hugely valuable process, I was just able to reflect on what was happening, what was going on in my professional life. And I was able to work through things, and deal with things". These sessions were funded and supported by the PHO where Kevin previously worked. Kevin explains, however, that maintaining this kind of relationship requires an ongoing commitment in the midst of other professional responsibilities and he has not managed to do this.

Kevin also describes a personal RP of writing in a journal and how this helps him makes sense of, and develop, his practice. Kevin writes about "what's going on professionally" but also talks about developing his "thinking, and thoughts, and link it to some of the literature I'm reading. So that's an important process".

A further aspect of reflection Kevin identifies relates to the continuing professional development requirements established by the professional body of GPs. One of these

requirements is that GPs participate in a peer review group for up to ten hours a year. Though Kevin values the typical review structure of the peer group, he notes that his group decided that they would use the Balint approach for some of their annual meetings. The place of Balint groups in RP was discussed earlier in Chapter 3, Section 3.3.2. Kevin contrasts the Balint group experience with the ways that doctors more commonly focus on RP as problem solving.

> *With the Balint group it's more about trying to reflect on what the doctor might be feeling. Or what the patient or client was thinking about the communication aspects, and the aspects of the consultation that kind of might have gone not so well, so that's how we run our Balint group.*

As Kevin recounts his different experiences of reflecting in different ways, he finds himself being critical of his Balint group, noting:

> *It's not as reflective as what it could be. I think it still operates in a relatively superficial level. But not as superficial as our normal peer group, which is more case based clinical discussions, kind of little reflection going on.*

Kevin suggests RP at the iwi provider can take a different form. He notes there is more focus on coming together as a team to carry out a range of activities. At the start of each day all the staff come together and this time is not focused on "clinical stuff". Yet, when there are clinical audits, these are also team-focused, rather than individual practice focused. Kevin also identifies more opportunities to engage with leadership:

> *The clinical manager involves me with some of the strategic thinking and, you know present ideas and we talk about ideas and present that to the CEO. So it's just the structure is different, there's a little bit more time.*

7.4 Overview of analysis of narratives at Site One

In both these narratives the main narrators sit outside the dominant part of our PHC infrastructure, the general practice. They strive to connect their work with what happens within the general practice but in different ways. John achieves this by striving to have a greater presence within the general practices, knowing that this will enhance patient care. At the same time he is conscious that the time and energy he invests in these activities is not funded.

Dominant processes of PHC funding and contracting sit at odds with how Martha and Kevin conceptualise the care they provide. Although Martha and Kevin are clear how they

want to work with the people who use their services, they also know that the PHC model situates the general practice at the centre of PHC. They do not seek to align their work in the iwi provider with the general practices, however, they recognise the importance of re-connecting the people they work with back to the general practices with whom they are enrolled.

The PHO appeared in a minor role in Narrative One as it was influential in initiating the grout project which supported the ongoing development of ICP between pharmacies, general practices and patients. In Narrative Two the PHO appeared absent from the interactions between the iwi provider and the general practices, at least insofar as the narrators were concerned.

7.5 Narrative Three – A community-based team provide primary health care

7.5.1 Key aspects of selected episodes

This narrative is situated in Site Two. It focuses upon the practices of interprofessional collaboration and reflection of a team providing community-based support services to people living with LTCs. The Wellbeing Support Team (pseudonym) was established and funded by Green PHO (pseudonym) to work with people living with LTCs. In a similar way to Narratives One and Two the practitioners here work in community settings outside of general practices. The Wellbeing Support Team, however, is funded directly by Green PHO which has comparatively secure funding from the Ministry of Health via their DHB.

When the interviews with practitioners in Narrative Three began, Green PHO had been running the Wellbeing Support Team as a pilot. Nearer the end of these interviews, Green PHO had determined they would continue with the programme. The Wellbeing Support Team comprises registered nurses and kaiāwhina who mostly work in nurse/kaiāwhina dyads. The team operates across a large geographical area where there are multiple small towns and one larger city. This results in the nurses and kaiāwhina commonly driving long distances. In addition to working with patients and their families, the Wellbeing Support Team liaise with GPs, practice nurses, and other health and social service practitioners across multiple organisations. Cross-organisation collaboration is identified in the literature as an important aspect of interprofessional collaborative practice. These episodes provide a view into how these multiple actors see this aspect of cross-organisation collaboration, what supports it, and what gets in the way of it.

The episodes selected for this narrative were taken from the text corpus as they are representative examples of the kinds of collaborative and RPs that happen outside of the general practice to support the growing population of people who are living in the community with LTCs. The Wellbeing Support Team prioritise working with people who are living with at least one long term condition and who have had more than two hospital visits, as well as multiple GP visits in the past year. The stories in these episodes demonstrate the kind of PHC that can be organised by a PHO to complement the work of general practices. At the same time, they demonstrate the complexities of both inter-professional and inter-organisational collaborative practice as well as the ways that general practices can influence what happens outside of their domain.

7.5.2 Storyline overview

There are two assemblages of episodes in this narrative with the first focused on the ICP between practitioners and the second assemblage focused on difficulties in inter-organisational collaborative practices encountered by the Wellbeing Support Team. Most of the episodes involve the actions of three main actors: a practice-wise registered nurse, Leah; an experienced kaiāwhina, Jane; and a new graduate nurse, Robyn. Robyn works half-time with Leah and Jane in the Wellbeing Support Team and half time within a general practice – named the Family Medicine Practice as they identify their model of care as traditional family medicine.

Table 14

Main narrators of Narrative Three

Narrators	Contextual notes
Leah – A registered nurse	Described as wise and experienced by all of the other actors and acts as a mentor.
Jane – A kaiāwhina	A dominant character in these episodes who identifies as Māori and draws significantly on a Māori world view as she describes her interprofessional and reflective practice.
Robyn – A new nurse graduate	A local of the provincial town where the Family Medicine Practice is located. Robyn works half-time with Leah and Jane in the Wellbeing Support Team and half-time for the Family Medicine Practice.

In the first assemblage of episodes Leah, Jane and Robyn describe how they operate as a collaborative team even when they are not in the same place at the same time. They constantly refer to the importance of building and maintaining relationships in their work: with each other; with the people they work with; with hospital-based staff; with all the

people working in all the general practices across their district; with statutory social services; and with a range of community-based health and social service agencies.

Their work commonly involves visiting *people/patients*[17] in their homes but equally importantly "just working together as a team with all the people that are associated with our patients" (Robyn). Similarly, Jane describes this as working "collaboratively with other services, agencies, practitioners, clinicians, social services across the board" (Jane). An important aspect of their work is consolidating the relationships between people/patients and the general practices where these people/patients are enrolled. The narrators' descriptions of this work of collaborating and making connections are filled with expressions of both hope and frustration.

A number of episodes in this first assemblage of episodes centre on the relationships that Leah, Jane and Robyn have with a GP (James) and a practice nurse (Claire) at the Family Medicine Practice (where Robyn works half-time) located in a small provincial town. The town at the centre of these episodes has higher rates of social deprivation than the national average, as well as higher proportions of Māori and Pacific peoples. Other episodes involve a clinical nurse specialist, Elsa, who runs clinics both within the local hospital and in community venues. The local hospital is situated in the same town where the Family Medicine Practice is located. Elsa works with many of the same people/patients who are also being cared for by the Wellbeing Support Team, and sometimes also visits these people/patients in their homes.

[17] The narrators refer to the people living with long-term conditions that they work with sometimes as *patients*, and sometimes as *people that we're working with*. To capture these two aspects of naming I use the term *people/patients*.

Table 15

Other narrators

Narrators	Contextual notes
Claire – A practice nurse James – A GP and co-owner of the Family Medicine Practice	Claire and James are in the Family Medicine Practice. Claire is at the centre of the stories of referral/non-referral to other providers. Both Claire and James are supportive of the work of Wellbeing Support Team.
Georgia – A project manager within Green PHO	Tasked with resolving the problems with collaboration that came up between providers in the second assemblage of episodes
Dianne – Clinical nurse manager responsible for the nurses of the iwi provider	Dianne's organisation runs a programme similar to that of the Wellbeing Support Team, though primarily working with Māori communities. Dianne and her nurses are located in the same provincial town as the Family Medicine Practice
Elsa – A clinical nurse specialist based in the local hospital who works extensively in community	Elsa works with health care providers across the region and works with all the providers in these episodes. She is very supportive of the Wellbeing Support Team, in particular, the work of Leah, Jane and Robyn.
Tracey – A manager of a general practice in a neighbouring town	Tracey compares the different ways that the Wellbeing Support Team works to that of the local team of the iwi-provider which operates in her town (separate from that of the Family Medicine Practice).

The second assemblage of episodes in this narrative centres upon a problem with collaboration which features in almost all the stories told by the participants at Site Two. The following organisations are all located in the same small provincial town and are involved in this problem: the Wellbeing Support Team of Green PHO, the iwi provider, the Pacific provider and the Family Medicine Practice. The iwi-provider and the Pacific-provider in this assemblage both run similar programmes to the Wellbeing Support Team that support people living with LTCs, though their services are more specifically targeted to Māori and Pacific peoples respectively.

A series of incidents related to referrals amongst these providers had been noted by the Wellbeing Support Team who discussed these with their team leader within Green PHO. At this stage the problem was thought to be a "doubling up of referrals" (Georgia) where the same patients had been referred to multiple providers to receive the same kind of care. Around this time, Georgia had been employed by Green PHO to carry out work on an un-related project. As the referral disgruntlements escalated the PHO determined they were in the best position as an organisation to lead a response to the problem and gave Georgia the responsibility to facilitate a way forward. Ultimately, Georgia was involved in organising five main meetings to resolve the problem. A synopsis of these five meetings is provided

here as this provides a view into the complexities of practitioners' behaviour and how this affects ICP.

Organisation of the first of these meetings happened prior to Georgia's involvement, however, Georgia was on board in time to facilitate this first meeting. The meeting included people from the iwi provider, the Pacific provider, the PHO, the Family Medicine Practice, and a person from the DHB responsible for contracting services from all of these providers. Georgia describes the meeting as "very uncomfortable to say the least." Nevertheless, agreement was reached that a group would meet to make sense of the problem with referrals.

Georgia reflects that she didn't quite get the people she wanted to attend the second meeting. Neither the practice nurse, Claire, nor the GP, James, from the Family Medicine Practice were there. This disappointed Georgia as the Family Medicine Practice had been identified as an important player having previously made referrals to all three of the community-based providers. The new-nurse graduate, Robyn, who worked half-time at the Family Medicine Practice attended. Georgia explains, she "was kind of representing the practice, but didn't have any power in the practice to do anything". Also in attendance were Dianne, the clinical nurse manager from the iwi provider, the person from the DHB responsible for contracting services, the person in the PHO with responsibility for supporting general practices, and nurses from all of the community-based providers.

The second meeting began by looking at the content of the referral forms and then identifying which patients were 'doubled-up' by comparing NHI numbers. Two significant discoveries were made: first, the referral forms of the different providers all had the same information on them, though were formatted slightly differently; second, there were no patient double-ups in the different community-provider services. Instead, it became clear that the main problem was a drop-off in the number of referrals from the Family Medicine Practice to the Pacific provider and to the iwi provider. It became clear that Claire was influencing other clinicians within the Family Medicine Practice to preferentially refer to the Wellbeing Support Team of the PHO. Consequently, Georgia was tasked with organising a third meeting to involve the nurses from all the associated organisations as they were the people involved in referring and accepting referrals.

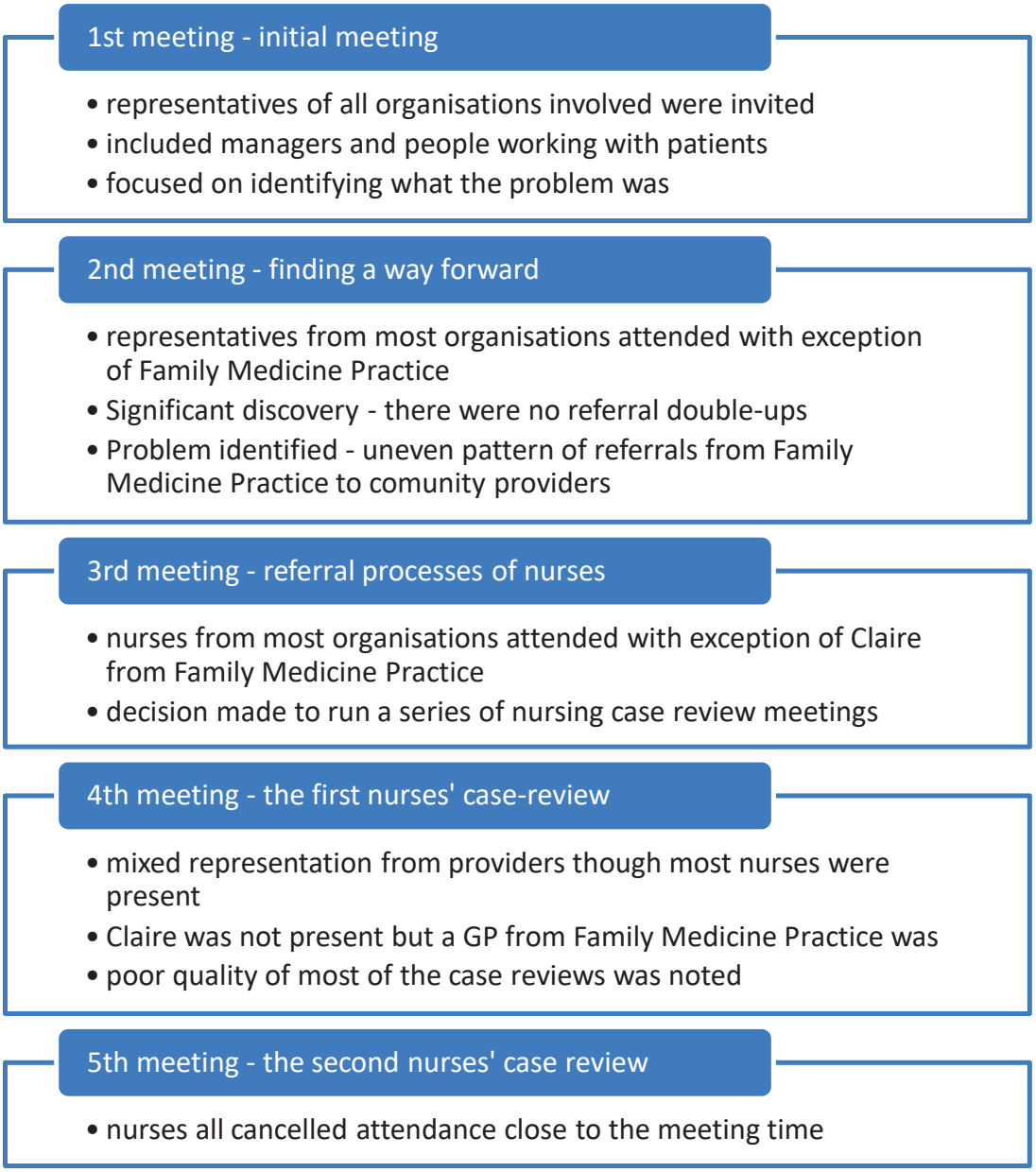
Nurses from all the organisations were present at this third meeting though, again, Claire from the Family Medicine Practice was absent. The intent had been to not have managers at this meeting, but Dianne from the iwi provider was present. The problems with

referrals were discussed with particular concerns about how to ensure practice nurses within the Family Medicine Practice made appropriate referrals to each of the community-based providers. Georgia notes that the general stance of the nurses was that patients should decide which community-based provider they wanted to be referred to. Dianne was concerned about this. Georgia and Robyn believe this concern was about the potential threat of not getting any referrals from Claire, with consequent contract funding issues for the iwi provider. Dianne attempted to convince others to establish a cross-service referral triage system, but this was not supported by others.

Two agreements were reached with difficulty at this third meeting. First, that referral forms would be modified to ensure practice nurses would ask patients their wishes on which community-based service they would like to be referred to. Second, that strengthening relationships between the nurses across the organisations would be helpful in improving referral processes and ultimately collaboration. Consequently, it was decided to start a regular monthly meeting for the nurses from the different services to present case reviews to each other. Georgia explains: “looking at case reviews and each other’s practice, would be a way of getting those relationships built, and looking at solutions”.

Figure 10

Overview of key meetings in second assemblage of episodes



The fourth meeting was then organised for the nurses to present their first case reviews to each other. Georgia was tasked with doing all she could to get Claire to that meeting, recognising Claire was key to making/not making referrals to the three different programmes. Claire was also seen by many of the narrators as being very experienced and being in a position to teach/mentor/develop the practice of the other nurses. Claire was not at

this fourth meeting, though one of the GPs from her practice, the Family Medicine Practice did attend. Georgia goes on to note that the presentation of case reviews did not go well:

> *The nurses that did do the case studies didn't come prepared as I had asked. And they obviously weren't skilled at doing case presentations. They-- it didn't reflect their practice properly, I don't think. The only one that was any good was Robyn.*

Georgia reflected on what it meant having the GP from the Family Medicine Practice present for these case reviews. On the one hand, "it was great that he had come, and he sat, and he watched." However, the presentations were poor and Georgia thinks it was not useful having him there seeing this:

> *It did appear as though the clinical practice of the nurses* [of the iwi and Pacific providers] *was not a particularly good standard. But you can't, you know, that could just be they didn't know how to present it, you know. I mean, very experienced nurses in some cases, but very inexperienced in another.*

Georgia concluded: "I should have perhaps invited him a bit later, once I'd kind of thought about it, and reflected on what had happened, I thought, 'oh, okay you didn't quite do this right'". Georgia took these reflections into her preparation for the fifth meeting: "You have to look at what's happened, and how you're going to, how you will do that next time, and what you're going to do to bring that together again". As a part of her thinking about "how am I going to sort this out", Georgia explains the plan that she came up with:

> *I put together a format for them to use, and I also put together a, like a little contract, about the confidentiality and the safety of people, so that we could build up that trust. Cos I realised that I probably should have done that before, that was part of my reflection was actually, you should have put all that in place before you had that meeting.*

However, relationships deteriorated between practitioners from this point onwards. Just prior to the fifth meeting (the second case review meeting), all of the nurses cancelled at the last minute. No further information beyond this time is available as field research had come to an end.

The objects, metaphors and values identified through analysis of Narrative Three are summarised in Table 16 and discussed in the following sections.

Table 16

Objects, metaphors and values of Narrative Three

	Assemblage 3
Objects	Lab results
	Hospital discharge letter
	General practice patients' notes
	Time
	Cell phone
	Referral forms
	Reports back
	Contracts
	Case Reviews
	Experience
Metaphors	Ground work and patch protection
	Transactional metaphors
	Navigation and activation
	Metaphors of time
Values	Building and maintaining relationships
	A Māori world view in establishing relationships
	Teamwork of the Wellbeing Support Team
	Mentoring
	Reflection
	Determination to provide good care

7.5.3 Objects

There were five objects at the centre of ICP and RP activity in the first assemblage of episodes: *the lab results; the hospital discharge letter; general practice patients' notes; time;* and *the cell phone*. In the second assemblage of episodes that related to the problems with referral there were another five objects: the *referral forms*; *the reports back* from practitioners who had received a referral; *the contracts* which fund the services; *the case reviews* which were the focus of the last two meetings; and whether practitioners were seen to have *experience* or not.

7.5.3.1 Lab results

The lab results (a.k.a. test results) are the results of diagnostic tests initiated by a clinician (typically a nurse or doctor) to gather information to assist with clinical decision-making. In several episodes the lab results are described as being sent to the GP, and/or as being located in electronic records that are primarily accessible to practitioners within

hospital services and general practices. The lab results are not, however, easily accessible to community-based practitioners like the Wellbeing Support Team who described difficulties in gaining access to these lab results (including lags in time of gaining this access). They see this as an impediment to the kinds of interprofessional collaborative practice they can provide. The strong collaborative relationship established between Elsa, the clinical nurse specialist, and the Wellbeing Support Team was named as an important mechanism for moving around this difficulty. As a clinical nurse specialist Elsa has access to the clinical information systems where lab tests are located.

> *So Leah has difficulty with accessing, you know the blood tests in a timely fashion, so she'll let me know when that patient has taken their bloods. And I'll check when the results are available and flick her a copy so that she's got access to it.* (Elsa)

There are many instances of these types of collaborations between Elsa and the Wellbeing Support Team.

7.5.3.2 Hospital discharge letters

Hospital discharge letters are written by practitioners in hospitals at the time people/patients are being discharged. They too are described as being sent to GPs, and/or as being located in electronic records that are primarily accessible to practitioners within hospital services and general practices. Although the Wellbeing Support Team will have commonly received a referral from a general practice to work with these people/patients, they do not receive up-to-date information about the movements of these people into and out of hospital. Even when the Wellbeing Support Team has found out someone has been discharged they need to initiate contact with the general practice to obtain further information. At these times, Elsa again works to keep information flowing to the Wellbeing Support Team:

> *So I try to keep them in the loop with what's happening and with access to, you know any other discharge letters on the DHB system that are related to that patient if we've got mutual patients. Just to, you know, cos they've got the same care for that patient and my focus is, you know, it's in the patient's best interest to, you know, to manage them as well as possible. So, you know, they need access.*

If the Wellbeing Support Team know that people/patients they are working with have been admitted to hospital they will often visit them in hospital so as to be clear what needs to

be put in place following discharge. Whilst visiting these people/patients, Leah and Jane noted they increasingly have access to the patients' notes within the hospital and have the opportunity to write in these notes. Although they see this access to the patient's notes as creating opportunities for interprofessional and interorganisational collaboration, Leah and Jane are often frustrated with these hopes for ICP not being realised.

In one episode Jane reflects they had come to an arrangement with staff on a hospital ward that the staff would phone the Wellbeing Support Team when the patient was due to be discharged:

> *I visited him in hospital and put some planning around what that looks like, and discharge, and the concerns of the family. And gave the nurses my take on things, and wrote some things down* [in the patient's notes]*, and it kinda still didn't happen.*

Jane expresses her frustration with not being contacted in spite of the efforts the team had put in:

> *The fact that we had visited, introduced ourselves, written in the notes as a precursor. I had a professional expectation that they would contact me and wanna have a discussion about how best to support this person should they come home.*

7.5.3.3 General practice patients' notes

Jane and Leah also see the potential for increased interprofessional collaboration coming from their access to patients' notes within the general practice. It is their hope that their work in the Wellbeing Support Team (and the comments they make in the patient's notes about this work) enables better relationships between the GP and their patient. Jane feels like she is operating in an uncertain territory, however, in knowing what to document. Jane is concerned that she is privy to information about the lives of the people/patients she works with, which is unknown to their GP: "Because they might not want their GP to know that, I'm there to, instead, I'm there to encourage them to have a relationship with their GP. So then they can tell, trust, their GP enough to do that".

Yet, there are times where Leah and Jane do successfully navigate this uncertain territory of documenting material that assists with the relationship between the people/patients they are working with and their GP. Jane notes, though, that the GP might not realise the significance of the background work the Wellbeing Support Team has carried out: "The doctor probably will never know that that whanaungatanga's happening, and

probably never ever will". Yet, Jane believes the interactions between the person/patient and the GP will be better as a result of the work the Wellbeing Support Team carries out. Instead of the GP beginning "okay what are you here for?" the GP is better able to make meaningful connections with the person/patient drawing on knowledge about them and their interactions with other parts of the health and social systems.

7.5.3.4 Time

The impacts of time upon ICP and RP are named by all the actors. Time is identified as something that was needed but scarce. The Wellbeing Support Team make many efforts to build and maintain ICP as they believe they have more time than practitioners in other parts of the health system. Jane notes, "we know that in hospital land there is no time, they're on case management, bed management, beds in, beds out".

Within the general practice itself, both GPs and practice nurses identified they did not have time, and this affected their ability to collaborate with others. For example, James, describes his daily routine commenting he just does not have time for collaboration:

> *I go in about quarter to eight in the morning, I come home somewhere between half past five and half past six. There are no breaks, don't get lunch, lunch is a sandwich in front of the computer going through results, doing referrals… consulting is 9:30 to 4pm, ten-minute slots.*

The Wellbeing Support Team agree that this lack of time in the general practice is an impediment to meaningful collaboration between themselves and these practitioners. For example, Robyn names the significance of time as she contrasts the potential for collaboration alongside the more common one-way process of practice nurses making referrals to other providers/practitioners: "Once a patient's been referred to the social worker, or the mental health team, or say us [Wellbeing Support Team], that connection's kind of lost". Robyn goes on to explain that practices nurses simply don't have enough time to "follow through with the patient" with the consequence that "once a patient's been referred on, unless they present back and initiate that conversation themselves, what they've done with say the mental health team, or the social worker, it kinda doesn't come up again".

Elsa similarly identifies the significance of time scarcity in the general practice and sees this as affecting interactions between the general practice and their patients: "There's so many barriers with access to the GP, with just trying to get an appointment with [the GP], getting phone calls back from the practice nurse… to hear results back about lab tests".

Consequently, Elsa finds herself in the situation of working outside of the general practice to close gaps in care and communication between people/patients and their general practice, as well as with the Wellbeing Support Team.

The Wellbeing Support Team describe a number of ways where they have time to carry out work that practitioners in general practices do not. One of these areas is providing transport for the people/patients they work with: "We're fortunate enough to have the time to pick these clients up and take them to-- if they need to go to appointments and things like that" (Robyn). Robyn describes the potential for relationship building: "They can't get out of the car when you're driving for an hour, so they've gotta talk to you. And it's amazing what you find out in an hour's drive". As a result, Robyn explains, "I learn about them, and their family, and how they're dealing with life. And they tend to trust you after you've had an hour in the car with them". Once they arrive at their destination the Wellbeing Support Team commonly accompany people/patients into their clinical appointment to offer support. They see this use of time contributing significantly to their collaborative practice with the people/patients they've transported as well as their collaborative practice with other practitioners.

7.5.3.5 Cell phone

All three members of the Wellbeing Support Team identify the significance of the cell phone to the mentoring, support and RP they carry out with each other: "So there's mentoring going on every day, I've been on the phone during my driving, talking" (Jane). Jane and Robyn highly value the mentoring conversations they have with Leah. In some instances they see these as opportunities for RP which link to the development of their interprofessional collaborative practice. Jane describes a common situation of where she ends up being highly frustrated at some work processes with another practitioner and so phones Leah who always manages to work with Jane "to find another way" (Jane). Reflecting on this process Jane notes:

> *You're still dealing with those same people. But the flow-on effect of that over time is you're starting to get-- build relationships, find out who they are, what makes that person tick… so you adapt yourself to suit, and the collaboration happens. Now if everybody had that, people would be working collaboratively.*

In addition to these reflective conversations on the phone contributing to better collaborative practice with other practitioners, Jane also describes these conversations as

contributing to better practice with the people/patients they work with: “So, because we’re always reflecting and discussing our cases in a reflective way, it broadens our understanding of what, what really needs to happen for that person”.

Robyn places the phone contact with Leah and Jane into a context of the broader technology that keeps them connected to each other:

> *We’ve got personal calendars that we’re all linked together so we know where each other are, it’s worked out really well. In the beginning I didn’t, I was like ooh freaking out because I was on my own. But now it’s just second nature, it’s normal”.*

The combination of the shared calendars, and the phone contact have meant Robyn does not feel like she is operating as a sole practitioner anymore.

7.5.3.6 Referral forms

The referral forms are a significant object at the centre of the referral problems in the second assemblage of episodes in this narrative. Practitioners in these episodes expressed hopes that engagement in the referral process would contribute to better care through increased collaboration amongst practitioners. However, they were commonly frustrated that these referral processes often did not result in such collaboration.

At the centre of the problems with referrals to community-based providers was Claire’s refusal to refer to the iwi-provider and instead refer almost solely to the Wellbeing Support Team of the PHO. Claire knew that this had “caused a little bit of an issue” but was clear on the rationale for her stance: “To be perfectly honest they’re useless, they cannot show me any outcomes, they want referrals because their funding is basically based solely on how many patients they’ve got”. Claire had not always taken this stance with the iwi provider and recalls her previous relationship with the iwi provider noting they had a “very good nurse” whom she referred to all the time. However, this experienced nurse left and was replaced with a less-experienced new graduate. Claire felt frustrated and annoyed at this appointment and relayed a series of situations where clinical outcomes with patients that she referred to the iwi-provider worsened. Claire concluded, “until they can show me some outcomes, I’m not prepared to send them referrals”.

7.5.3.7 Reports back

Once a referral has been made, the referring agency expects reports back from the practitioner they have made the referral to: "It's gotta be a circle, you know it's gotta come back" (Claire). Sometimes these reports back happen through phone calls or face-to-face meetings, but they can also be in written form via emails or IT systems. The reports back are named as key to expectations of collaborative working. Problems with report backs were at the centre of Claire's decision not to refer to the iwi provider. Claire identified the reports back from the previous nurse at the iwi provider as key to their collaborative relationship:

> *She used to bring me a handwritten summary and we would go through each page and then have a discussion about where they* [the patients] *were at and whether they were ready to be discharged or, you know. Her and I did collaborate very well together, and I miss her a lot. So yes, so I do think it has to be a two-way street.*

Claire goes on to contrast this with the relationship she had with the new less-experienced nurse, where the new nurse was not reporting back with results.

> *Where's the satisfaction in that for me cos I don't know what's going on? How do I know the patient's benefitting, the person, client, whatever you want to call it is benefitting? And how do I know that they are being provided with some kind of service?*

The Wellbeing Support Team place high value on these reports back following referral. This is recognised favourably by practitioners like Claire and Elsa. As Elsa contrasts the way that the Wellbeing Support Team work compared to the teams at the iwi-provider and the Pacific-provider she concludes: "[The Wellbeing Support Team] are more pro-active with getting in and feeding back to the GPs. And I see them being in there and talking to the practice manager, and giving an update, and meeting with the GPs".

7.5.3.8 Contracts

The community-based programmes offered by the iwi-provider and the Pacific-provider do not have secure funds and rely on multiple short-term contracts with funders like the Ministry of Social Development and the Ministry of Health. Typically, these contracts are based on the numbers of people that they are providing services to. This has the unintended result that providers can feel in competition with each other to have people on their "books". In these episodes this was named as a contributing factor with Georgia thinking that fears for future funding were present for the iwi-provider throughout the

meetings: “they thought they weren’t going to get the referrals; they wanted to have charge of how those referrals came, and where they went to”. This tension between providing the care the patient needs and the pressures of contracts was also named by Robyn who noted: “they’ve been really reluctant to have our service here due to funding. Because everything comes back to money, due to funding, and worrying about us taking patients away [from their service]”. The security of the funding flow to the general practice, stands in stark contrast to the need for the iwi provider to constantly justify the work they do to secure their temporary contracts.

Dianne, working in the iwi-provider, also spoke about funding, though in a different way to these ideas expressed by Georgia, Robyn and Claire. For Dianne, the nature of being in a small community and operating with multiple funding contracts necessitates the iwi provider working collaboratively with other providers: “We have contracts from the Ministry of Health, and also from the PHOs. So we have Green PHO contracts and Orange PHO contracts”. Dianne reflects the iwi provider “sort of sit in the middle, and it’s an uncomfortable kind of relationship”.

7.5.3.9 Case reviews

The case reviews (a.k.a. case studies) were established as a way to build stronger relationships amongst the nurses from the different providers in these episodes. Though the vision of these was not realised, their potential contribution to these relationships was recognised by the narrators: “Referrals don’t work unless you know who you’re referring them to, and the person you’re referring them to, knows you” (Jane). As Georgia worked to resolve the inter-organisational collaboration problem she put much energy into the relationship between Claire and the new person at the iwi provider with the hope that Claire would participate in these case reviews.

> *It’s about the one person* [Claire]*, really, that has a lot of influence in the practice. Not having that relationship, or that trust, with the new person that’s come on board* [at the iwi-provider]*. And some of it’s because she doesn’t know her, which is what I was hoping I could try and get that relationship going, try and get the case studies so they could see each other’s practice.* (Georgia)

This vision was not to be realised.

7.5.3.10 Experience

Whether practitioners are perceived to have *experience* or not features as significant in these episodes of problems with referral across organisations. The referring practitioner wants confidence that the referral will result in good care of the patient, particularly given the nature of LTCs. For example, Claire describes some of these people as "difficult diabetics, difficult people that have got different social circumstances and not getting access to everything they need". Georgia echoed the importance of experience when working with people with LTCs: "experience is actually really, really valuable. You know, they're very complicated patients".

Dianne reflects, however, on the different kinds of experience people bring to their roles:

> *When you get a nurse you're not necessarily getting just a nurse, you're getting a nurse plus all the things that they've learnt, and experienced and, you know, and with an aging population people are getting lots of experiences by the time they're in their late 40s, early 50s aye?* (Dianne)

Perceptions of experience/inexperience varied. Claire claimed "they've employed a very inexperienced nurse, a brand new graduate who has got no experience at all". In stark contrast, Georgia recognised the new graduate as having relevant experience: "She's got so much behind her from her life experience. So, she was a care assistant in a local rest home for 20 years". This linking of experience with being local was identified as important by both Georgia and Dianne. In one episode Georgia is describing attributes of the Wellbeing Support Team which contribute to them being able to carry out their work so effectively: "Robyn's got ties to the community, she lives here, she's got kids, she's got good life experience, she's a good example".

7.5.4 Metaphors

The metaphors used in this narrative provide important glimpses into the nature of the ICP interactions and the ways RP contribute to these. Notions of doing the *ground work* and *people working on the ground* sat in tension with, people protecting their patch of ground. This *patch protection* was strongly associated with *transactional metaphors* being used to describe the place of patients in the health system. Additionally, a range of metaphors drawing on processes of *navigation* and *activation* lay at the heart of how the Wellbeing Support Team described the way they see their ICP. Finally a number of

metaphors of time were used including *taking time*, *consuming time*, and *having time on your side*.

7.5.4.1 Ground work and patch protection

As Georgia described the difficulties in the second assemblage of episodes, she used a number of metaphors relating to the ground: "maybe the ground work wasn't done, or the wrong people were involved. The people on the ground were really happy, but it was the people higher up that weren't. And some of that was patch protection" (Georgia). Jane too referred to these people on the ground: "if all the managers left the room, and left the kaimahi[18] at ground level to discuss these things, then we would get some outcomes and solutions". Indeed, Jane thought the essence of collaboration is allowing practitioners from multiple organisations to do things with each other at ground level, and that this is what leads to better care. She acknowledged that standing against this way of working were concerns by managers in protecting their patch from incursions.

7.5.4.2 Transactional metaphors

This patch protection particularly related to contracting, and was visible in the transactional metaphors which were commonly used to describe the connections between the patients/people needing care and the contracts issued to provide that care. Robyn noted that "everything comes back to money, due to funding, and worrying about us taking patients away [from them]". Georgia, describing this same worry, referred to "*the volumes* they see." These transactional metaphors convey a sense of protection of patients as a source of revenue from other providers.

When funding is not secure (e.g. for the iwi provider) then organisations with less economic power attend carefully to their relationships with contract decision-makers. Dianne describes the way this dynamic impacts on the efforts she puts into making things work between the iwi provider and those who provide them contract funding, like the PHO: "when money's involved it's a different dynamic, yeah. So, when one party holds the money and says if you don't do this we're gonna stop the money, then that's a very powerful dynamic".

In spite of the dominant interference with collaboration from contracting dynamics, the transactional metaphors, can also represent hopes for potential collaboration amongst

[18] Worker or employee.

practitioners across different providers. As Claire reflects on the potential collaborative practices associated with referral processes she uses terms like “a two-way street” and notes that the referral process has “gotta be a circle” (Claire).

7.5.4.3 Navigation

Leah and Jane see one aspect of their role as assisting the people/patients they work with to surmount challenges they encounter and navigate their way through health and social service systems. At times this navigation means supporting the cultural perspective of the people/patients as they engage with culturally unfriendly health services/practitioners. It may also mean supporting people/patients in other ways, for example, “you’re not used to asking questions of health professionals, or you don’t know where to go for social services” (Jane). In these instances, the Wellbeing Support Team helps them navigate this foreign territory.

Skills in navigation constantly tread a fine line between directly supporting people/patients to meet their needs, in contrast to enabling the people/patients to meet their own needs: “I just need to connect you with someone, or, actually I need to walk with you” (Jane). Robyn and Jane illustrated some of this complexity as they reflected on the task of transporting people/patients to appointments. Although it is sometimes a required activity to assist people to navigate their way through the health system to meet their needs, they are also conscious that providing transport can create co-dependencies.

At times, their health navigation role focuses on supporting people/patients to use other forms of transport themselves to get to appointments, like shuttle services. In this way navigation can involve introducing them to the idea of the shuttle service.

> *What I try and do is introduce them to the concept, or to the ideas of the shuttle services. And how you can access that, and, you know so they might be more than happy to use the shuttle service. But* [sometimes] *accessing it is the barrier or the problem.* (Jane)

In these instances, Jane notes, she can organise to “meet people at their appointments, so there’s still the element of engagement where we will be there with them” (Jane). These navigation scenarios require the Wellbeing Support Team to have strong collaborative relationships with a range of practitioners and providers:

> *Just having that network or connection with the shuttle people where if they can’t get hold of the patient the night before, there’s a second contact to ring.*

> *And so it might be just our-- a phone call that we have to answer to say "yeah, yeah, no, we know how to get that patient a message" or whatever.* (Jane)

7.5.4.4 Activation

Jane sometimes used the term *activating people* which she defines as enabling them "to grab onto what it is they need to grab onto to pull themselves up and then ensure that they have access to things to keep themselves up". Activating people requires ICP with practitioners, providers and the people/patients themselves. An important component of this, is constantly evaluating what people/patients know and what they don't know. The Wellbeing Support Team know that GPs and practice nurses commonly assume what patients know and send them away believing as clinicians they have finished their tasks. Yet when the Wellbeing Support Team go into people's homes they discover what it is the people/patients do not know. Robyn reports two examples: "they take the pamphlet home and it goes over there [on the dresser] and that's it"; "I had a lady that had been given her asthma pump, the doctor said 'it's for your chest.' So what does she do? [squirt sound] onto her shirt to her chest area".

Although Leah, Jane and Robyn recognise the impacts of time-scarcity on the actions of GPs and practice nurses in these situations, they are also conscious of much interpersonal communication complexity in these situations. Robyn explains a common scenario of people/patients saying to clinicians "Yeah, no, I know what you're talking about" when in fact "they don't actually comprehend anything". She notes the high number of people they deal with who are illiterate, but the doctor does not know this.

7.5.4.5 Metaphors of time

In the previous section on objects, time was described as something that practitioners either had or did not have. However, other ways of talking about time were also used with time sometimes being personified. For example, the Wellbeing Support Team talk about having time on their side to support their work, or time allowing them to carry out some tasks, like visiting the hospital and attempting to set up a collaborative relationship to enable post-discharge care. On occasion, the Wellbeing Support Team named a determined effort *to take the time* to build relationships with practitioners: "It can take a long time. Like you've gotta keep pushing at it, you've just gotta keep pushing at it" (Robyn). The motivation for this perseverance is to ensure it will be "smoother for the patient when they come out of the hospital and back into the community" (Jane).

In general practices, time was also described as *being under pressure* and being *consumed* by tasks. As James was naming the large number of patients he sees each day in the 10-minute appointment slots he notes "the pressure on time is huge". Similarly, the practice nurse Josie describes the impacts of administrative tasks related to seeing patients:

> *Every patient you see, you have to write down everything you've done for them which is quite extensive. And so you need to be able to see them and get it written down in the shortest time. And then every patient you see can be another referral … multiple jobs related to it, so it's all very time-consuming.*

The scarcity of time within general practices is also recognised by people outside of the general practice. Those outside see this impacting negatively on their ability to work collaboratively with practitioners inside the general practice and modify their expectations around interactions with GPs and practice nurses. For Jane and Leah this means limiting the number of people in the Wellbeing Support Team that a GP needs to have a relationship with: "It's the GP who Leah is clinically working with and having that dialogue with, and problem solving with, and keeping them in the loop" Jane explains. A part of this rationale for Leah and Jane is that nurses have clinical responsibilities related to law and professional registration that kaiāwhina do not: "I don't need to be another person that a GP has to have a relationship with. Like, I get that they've got so much to do with so little funding, money, time" (Jane).

In contrast to the time scarcity within the general practice, all of the narrators see the Wellbeing Support Team see as having time for ICP, and identify this as strongly connected to their role: "If it's gonna take an hour to see this person, or to meet with the heart failure nurse to introduce our service and what we do, and make a bit of a link with her, then we can" (Robyn). This is reinforced by Georgia, who contrasts the work of a district nurse with a nurse working on the Wellbeing Support Team:

> *A district nurse has a list of 15 people that she's got to do, in 8 hours, and she has to fill in every 5 minute increment, you know. So, that ability* [by the Wellbeing Support Team] *to, you know, if this person needs 2 hours of my day today, then they've having 2 hours.*

7.5.5 Values

7.5.5.1 Building and maintaining relationships

Building and maintaining oelationships is key to the interprofessional collaborative practice of the Wellbeing Support Team. This is evident in many of the explorations of

objects and metaphors identified in the analysis above. It is equally important for them to build and maintain relationships with the people/patients they work with, as it is to build and maintain relationships with other practitioners and they see strong synergies with these two aspects.

> *We've got one patient that has a really good relationship with the heart failure nurse. And because we'd made that link with her and he brought his walls down because he understood that we're kinda on the same page as her, you know and we're working together for him. But prior to that he was a bit guarded.* (Robyn)

They see better care and improved clinical safety as results of this focus on relationships:

> *I feel safer within my practice because I've built relationships with other services that are involved. And I know a little bit more about what's going on with the patient, versus just going in and kind of just focussing in on what I need to do. I also know what other people are trying to achieve as well. (Robyn)*

Collaborative ways of working with practitioners have developed through their relationship building. The ways that Elsa works with the Wellbeing Support Team demonstrates the collaboration on patient care that becomes possible. In one story Elsa describes the way she works with Leah to determine patient contact around who will do the first visit, the blood tests, and then the follow-up visit with a new patient once the lab results are known: "depending on who's in the area and who's doing what, so we just sort of work in with, you know, and figure out who's doing what" (Elsa).

7.5.5.2 A Māori world view in establishing relationships

The Wellbeing Support Team identify the importance of a Māori world view to this valuing of relationships and in establishing a foundation for ICP. They commonly use the terms whanaungatanga[19] and whakawhanaungatanga[20]. When establishing relationships with practitioners: "whakawhanaungatanga is about who are you? Where do you come from? What do you do? Who are you working for? What type of patients do you work with? You know, who else do you know, you know, whatever!" (Jane). Jane argues that the practice of whanaungatanga enables collaborative practice as it supports effective referrals: "Referrals

[19] Whanaungatanga translates as relationship or kinship. Moorfield suggests it connotes a sense of relationships that are developed through shared experiences and working together which provides people with a sense of belonging.
[20] the term whakawhanaungatanga is commonly used to describe the process of whanaungatanga.

don't work unless you know who you're referring them to, and the person you're referring them to knows you". Jane contrasts the relationship-building she identifies with whakawhanaungatanga to other approaches: "Pakeha networking is just 'oh, how do you do?', and shake hands, and you sit there, you know swap business cards" (Jane).

Jane's leadership in weaving a Māori world view into the practices of relationships within the Wellbeing Support Team is acknowledged by both Robyn and Leah and influences their work with people/patients.

> *You've gotta have family involved, if you don't have them involved, especially the Māori families because quite often you'll go and visit the patient and there's a whole lot of other whanau at the same time. So if you haven't established that relationship with their whanau, you kind of get stared down, and you know they're kinda watching your every move. Whereas if you've made that relationship, and you can have a joke and a laugh with them, they're quite at ease when you're visiting their dad, or their grandad, or whoever you're seeing. It's definitely worthwhile.* (Robyn)

For Robyn, being a town local helps with this whakawhanaungatanga: "A lot of the patients that I see, I either went to school with their children, or their grandkids, or I can establish a link like that". Robyn notes though, that it is still possible to work in a district where you do not have such direct links, "you just have to work a bit harder at establishing links, and building that rapport, and doing things like that".

What Robyn has found harder, however, is taking this practice of whakawhanaungatanga into her work in the Family Medicine Practice. She explains, "I try and take that to the general practice and when I'm dealing with the clients there I try and establish that link with their family, or question things a little bit more. Versus, come in, fix it up and move on." Although Robyn reflects that this has got a little easier with time, it is still not easy: "it is hard to still try and bring that to the general practice, cos sometimes it can be quite a disjointed workspace". It appears that context can impact on the ability to hold onto this valuing of relationship building.

7.5.5.3 The teamwork within the Wellbeing Support Team

Due to the wide geographical area they work in, Leah, Jane and Robyn will frequently be visiting people/patients in their homes by themselves. This does not stand in the way of them operating as a team as demonstrated in this interchange between Jane and Leah:

Jane: I guess we're a team, so it doesn't matter if I'm sitting in a patient's home and they haven't met Leah yet, I'm talking about her like she's there, right?

Leah: Mmm, and I do the same thing, I talk as, "you haven't met Jane, but Jane is the other part of my team"

Jane: From the get go, and yeah "Leah's this person and she's that person, and this is what she's good at, and she's got all of this knowledge, and she just works with you", and so I'm promoting who she is as a person and again and it's that, I'm creating that, I'm opening up that realm of whanaungatanga, I'm opening up that realm of I don't stand alone.

Robyn too describes this aspect of them being a team even when they are not together:

Yeah, we always introduce ourselves as a team, so even though I don't see half the patients up there, Leah will always say, "there's my colleague Robyn, and our kaiāwhina, Jane, and we all work together, and you'll probably meet them one day, but we're just gonna take steps towards that at the moment.

They place high value on the supports they get from each other which enable them to operate collaboratively which is evident in their use of terms like: *balancing*, *supporting* and *trusting each other*. Jane notes at one point, "Leah balances me" which leads to Leah to respond:

When I stand next to Jane, and we're in that space, Jane gives me the confidence, Jane is the other part of this role, Jane gives me the confidence, or it's not even confidence, it's the, the essence to be where I am in doing what I'm doing, and in the cultural context. Some places I will hold my own, other places I need to be standing right next to Jane or behind her.

The supportive and collaborative way that Leah, Jane and Robyn work with each other is highly visible to others. Georgia describes a common process she sees: "when something comes up, and they're not quite sure, then they contact each other, and there's that sort of give and take along the way." Leah, Jane and Robyn note, though, that this trust and support does not mean they always agree.

Jane and I can agree to disagree and feel quite professional in our places that we do. And we can come back and resolve where we feel, and carry on working together. So it is a kind of a special relationship and it's quite a trusting relationship in both ways. (Leah)

7.5.5.4 The importance of mentoring

Mentoring is highly valued by many of the social actors in this narrative. Robyn and Jane told a number of stories about the mentoring they received from Leah and from Elsa. In one story Elsa describes a problem Robyn was working through with a patient: "he'd had a run-in with the receptionist, and so he'd been barred from the practice. And he was a high-risk Māori cardiac patient, you know with a big family history". Elsa recalls the phone call where Robyn relayed, "I'm really worried about him. You know, like he can't see the GP and he's running out of medications, and I don't know what-- he's gonna end [up] with you in hospital" (Elsa). Elsa describes the supportive conversation she had with Robyn to help her find a way forward. Later, Robyn also spoke about this situation and explained how grateful she was for the guidance from Elsa on finding a way past the difficulties with the receptionist and the practice manager of this general practice.

7.5.5.5 Reflection

Reflection is highly valued by many of the social actors in this narrative. For Jane and Leah, being able to collaborate is strongly related to their capacity to reflect.

> *If I look at Jane and I, working in a collaborative model, and we're reflective. When I'm struggling for whatever reason, so I'm studying and I've got all this other stuff going on, or something happens, my level of passion might go down the manometer*[21]*. And Jane will go "that's okay I will jump on the horse at the front and I'll keep the ship moving in the right direction"* [Jane: mmm, mmm] *And then what will happen is that there'll be an equilibrium, and then something will happen in Jane's side, and I will go, "that's fine, I'll jump up the front of the horse."* (Leah)

It was clear, too, how much Robyn valued reflection: "Pretty much every day I'm like, not 'could have, would have, should have', but you know, thinking about things that I've done during the day, and what went well, and what didn't go so well". In addition to reflecting with Leah and Jane, Robyn describes a number of other ways she carries out these reflections referring to her relationship with Claire and a social worker colleague in the same town.

Elsa, too, highly values reflection which she identifies as commonly occurring with others, particularly the Wellbeing Support Team and another CNS colleague. Elsa notes that

[21] A manometer is an instrument used to measure and display pressure.

being in regular contact with these colleagues contributes significantly to the capacity for reflection. Referring to her CNS colleague she explains:

> *We speak most days, we'll ring up and catch up. And we have a set meeting day on a Friday with the cardiologist that we're in Hamilton, so usually we'll make time in that day, you know in the afternoon to sort of meet and have a quick catch-up.* (Elsa)

Elsa contrasts the kind of reflection that happens with the people she works closely with, to the kinds of reflection she does for her professional portfolio (PDRP) noting she values more her reflections with colleagues as they are "more concrete and more specific to what I'm doing, and actually looking at how it impacts on my practice". In contrast:

> *Probably the PDRP is a bit more general, looking at how the roles, you know what you do as that role, how it's improved with the other things that you have access to with the postgrad learning. And the sorts of things I do in regard to networking with the teams and setting up study days and, you know presenting at conferences and doing, you know abstracts and stuff and all that.* (Elsa)

Elsa identifies a number of barriers to reflection including the amount of time she spends driving across the district to appointments and the time-consuming nature of regular work activities. These work task time pressures were also named by the Wellbeing Support Team. Even though they named the ability to make time for their work with people/patients, this was always prioritised above making time for reflection.

Nevertheless, Elsa sees the way that the Wellbeing Support Team works with general practices to be different to the other providers across the district. A valuing of a strong personal critical reflective stance seems to sit at the centre of this difference. Elsa notes they are quick to engage with her as a clinical nurse specialist who has knowledge that can help them to carry out their work better: "They've readily said 'we don't know much, but we're keen to learn'. And they ring up".

A consequence of this personal critical reflective stance, Elsa believes, is that this team has developed their confidence in engaging with the GPs:

> [They are] *able to confidently say to the GP "no, you need to do this", or "this medication needs to be adjusted because of this", and "I've discussed it with Elsa and this is what we're gonna do, and we're gonna monitor it." And, you know, so they have got that rationale behind what they're presenting to the GP.*

7.5.5.6 Determination to provide good care

The Wellbeing Support Team are determined to do what is best for the person/patient, even when this action requires working differently or doing something that is difficult, for example having the challenging conversations with hospital staff around discharge. This value of doing what is best for the person/patient was also visible in the text of other narrators. For example, whilst Georgia navigated the challenges of the inter-organisational dynamics related to the problem with referrals, she persevered noting, "we wanted to actually do what's best for the patient, for the person".

Similarly, even though the actions of Claire (in not referring to the iwi-provider and the Pacific-provider) were at the centre of much conflict, these actions too appeared informed by a strong value of Claire wanting better outcomes for the person/patient. As Claire described the programme being implemented by the Wellbeing Support Team, she comments: "they've had some good results, really good results of people that just were going nowhere. And I just think it's the best thing since sliced bread".

In spite of the difficulties in relationships outlined in the second assemblage of episodes in this narrative, Dianne was very positive that all of the practitioners and providers involved in the meetings wanted what was best for people/patients: "Everyone in the room is really determined to give good care. And there's no, there's no issue about that, it's [the problem's] not about client care, everyone's doing their absolute utmost, yeah. I don't see anyone that's, you know trying to dodge anything". Nevertheless, Dianne also recognised that the way the health system operates means the iwi provider has to be determined in thei approach as a result of where they fit in PHC provision: "the sick person comes in, you know, they sort of-- the DHB does the first part, you know, the PHOs pick up the next part. And who doesn't come to the GP? And who doesn't come to their appointments? And who's getting sicker at home with no phone? That's the work we pick up, and that's like the real work" (Dianne).

7.6 Narrative Four – The re-organisation of PHC in a small provincial town

7.6.1 Key aspects of selected episodes

The episodes in this narrative are all situated in Site Two and focus on the major re-organisation of PHC services within the small provincial town which featured in Narrative Three. These kinds of re-organisation of PHC services have happened often in recent years

in Aotearoa/New Zealand as a result of changes of government and implementation of new priorities on how PHC is organised. These episodes were chosen to draw attention to typical processes associated with this re-organisation and highlight intersections with the practices of interprofessional collaboration and reflection.

The establishment of the PHO infrastructure in Aotearoa/New Zealand begun in 2001 was intended to bring about marked change in PHC provision. However, throughout shifts in the health system to establish the place of PHOs, the general practice has remained central and powerful. This has a strong impact upon ICP and RP, particularly because GPs and practice nurses in general practices argue they are too time-poor to drive process of collaboration and reflection. The episodes in this narrative shed further light on the complex relationship between general practices and PHOs. The narrators in some of these episodes reflect on how co-location of services affects what they do. Analysis shows there is much complexity in the relationships between co-location and collaboration.

The re-organisation of PHC analysed in these episodes occurred alongside a decision by the DHB to review both primary and secondary services in this district, and particularly within the small town at the centre of these episodes. Action was prompted by the following concerns which were named in a 2009 report that the DHB had commissioned from a consultant: fragmentation of care between the primary and secondary sectors; difficulties attracting permanent medical officers to staff the local hospital; the ageing demographic of the local GP workforce with associated difficulties in recruiting new GPs; and the state of dis-repair of the local hospital buildings.

Prior to the re-organisation of PHC there were two pharmacies and four general practices in the town centre. The hospital in the town was located two kilometres outside the town centre. The four general practices collectively provided services to approximately 15,000 enrolled patients. The intent of the re-structure was to combine the general practices into one. This goal was not realised, however, and by the end of the re-organisation there were two general practices with each aligned to a different PHO. This complex process took five years to implement and involved the dis-establishment of organisations, the re-location of old organisations, the establishment of new organisations, and the significant refurbishment of previously mothballed wards within the local hospital to accommodate the new organisations.

Analysis below focuses primarily on the texts obtained from interviews. However, information about the re-structuring processes from other sources was drawn upon to provide a context for this text. This included information from several reports written at the time, several articles published in the local newspaper, and key information from Orange PHO about the new model of care they were implementing in their general practices at this time.

7.6.2 Storyline overview

The Family Medicine Practice lies at the centre of most of the episodes in this assemblage. Two of the four main narrators in these episodes work within this Family Medicine Practice and were introduced in Narrative Three: James, a GP and co-owner; and Claire, one of the practice nurses. The two other narrators in these episodes observed the processes of re-organisation. Georgia is employed by Green PHO as a project manager, and Cynthia who is a local pharmacist. All four of these narrators relay stories of how things were before the re-organisation, key occurrences along the way, and how things operated afterwards.

The objects, metaphors and values identified through analysis of Narrative Two are summarised in Table 17 and discussed in the following sections.

Table 17

Main narrators of Narrative Four

Narrators	Contextual notes
Claire – A practice nurse in the Family Medicine Practice James – A GP and co-owner of the Family Medicine Practice	As a co-owner, James was a key player in the negotiations and decisions associated with resisting amalgamation. James and Claire both describe how they work with co-located services in their new premises.
Georgia – A project manager within Green PHO	Worked with the Family Medicine Practice on several projects across several years following the re-organisation. She provides a view from outside of this amalgamation and also on how the Family Medicine Practice operates.
Cynthia – A pharmacist in the newly established pharmacy on the hospital site	Cynthia has worked as a pharmacist for a long time in the town and had previously worked in both of the old pharmacies. She works closely with both of the general practices on the new site.

The narrators all agreed that something needed to change about the way PHC was organised in their town around the time of the DHB review of services. Georgia explained: "a lot of the GPs were, they were past retirement, they were wanting to retire, and they

couldn't retire, because they couldn't get anybody to come, or buy the practice, you know, or work in the practice either". In addition to this, James explained, their consulting rooms which had been built forty years earlier, were no longer fit for purpose.

James, Georgia and Cynthia all recalled the discussions and negotiations around the different options for re-organisation of PHC proposed by the DHB. Cynthia remembers "there was a degree of negotiation, discussion, and resistance that went on for a few years". A key factor in the negotiations and discussions was a recognition by all four general practices that all of their premises were dated and were no longer conducive to best patient care. At this time all four of the general practices were members of Orange PHO who played a major role in the re-organisation negotiations. Ultimately Orange PHO bought out three of the general practices and combined them into one. The Family Medicine Practice, however, resisted this amalgamation and opted to remain a separate general practice. It ultimately aligned itself to another PHO.

The objects, metaphors and values identified through analysis of Narrative Four are summarised in Table 18 and discussed in the following sections.

Table 18

Objects, metaphors and values of Narrative Four

	Assemblage 4
Objects	Mothballed wards
	Orange PHO new model of care
	Hospital corridor
	Electronic referral (a.k.a. the e-referral)
Metaphors	Personal distancing metaphors: afforded an appointment; you can't have your doctor; going through the e-referral
	Connecting with people metaphors: wandering across; popping in
Values	Traditional family medicine
	Local long-term relationships between practitioners and the community
	General practice independence from the PHO

7.6.3 Objects

Objects in this assemblage of episodes were the *moth-balled wards, the Orange PHO new model of care, the hospital corridor*, and *the electronic referral* (a.k.a. the e-referral).

7.6.3.1 The mothballed wards

The five narrators in these episodes all referred to these mothballed wards in the hospital as they explained the reorganisation of PHC and how the amalgamation of multiple providers unfolded across time. The mothballed wards were refurbished to re-locate the newly amalgamated general practices and pharmacies. The narrators identify connections between the co-location of their organisations in these wards and ICP. These are discussed later in this analysis.

Refurbishing the mothballed wards was not one of the solutions proposed by the authors of the initial report commissioned by the DHB to review primary and secondary services in the district. Indeed, the most strongly supported of the four proposed options was to build a multi-million-dollar integrated family health centre in the central business district. The proposed centre was envisioned to co-locate hospital services, social services and PHC services. In refurbishing the moth-balled wards, the DHB and Orange PHO chose a cheaper option but continued to articulate their vision that co-location of these services in the mothballed wards would lead to increased collaboration and integration of PHC and secondary care. The extent to which this has occurred is discussed later in this analysis.

Early in the amalgamation discussions, the Family Medicine Practice planned to remain located at the town centre, knowing that the new general practice was to be located two kilometres away on the hospital site in one of the newly re-furbished mothballed wards. They re-visited this decision, however, as amalgamation of the other services progressed, and it became clear that laboratory testing as well as the new amalgamated pharmacy were also going to be re-located to the refurbished premises on the hospital site. Renewed negotiations between the Family Medicine Practice and Orange PHO resulted in Orange PHO expanding their development at the hospital site. They negotiated with the DHB to refurbish one of the other mothballed wards to accommodate the Family Medicine Practice.

7.6.3.2 The Orange PHO new model of care

The *new model of care* implemented by Orange PHO in the new amalgamated general practice is key to several plot movements in these episodes: the expectations of Orange PHO as they strived for amalgamation; the design of the premises for the new general practice that was built in the mothballed ward at the hospital site; and the rationale for resistance articulated by the Family Medicine Practice.

Georgia, Cynthia and James all spoke about how the co-owners of the Family Medicine Practice did not like the new model of care. James explains: "It did not particularly appeal to myself and [name of co-owner] as a way of running our practice and managing our patients to the best of our ability. And we decided that we didn't want it, and so we decided to change PHOs" (James). From the outside looking in, Georgia noted, "They wanted to retain their practice, and they wanted to have the say-so about how they practiced, and all the rest of it, and the model that they used" (Georgia).

At the time of the interviews with these practitioners, the new general practice of Orange PHO had been operating for two years implementing its new model of care. James, Georgia and Cynthia all believed that many patients did not like this model and were changing their enrolment to the Family Medicine Practice as a consequence. James explains how the new model works and why he believes patients do not like it:

> *They phone up for an appointment and they speak to someone in* [name of a distant large city]*, rather than the receptionist that they've known for the past 20 years… and then they're afforded an appointment, and they don't know if it's going to be with a nurse, with a physician's assistant, or with a doctor. They are not really allocated to any one GP anymore. It is meant to be just, you know, not quite drop-in, but it's, integrated* [said with derision] *so that it doesn't really matter. But it <u>does</u> matter to some patients.* (James)

Another aspect of Orange PHO's new model of care is their implementation of virtual consultations. These utilise more email and phone contact with patients, as well as encouraging patients to utilise patient portals to increase their communication with the PHC team. James does not like virtual consultations and expresses suspiciousness about the patient portal:

> *I don't know that there's a place for that here. I want to be able to see my patient and talk to them. I want to be able to take their blood pressure, I want to be able to see if they've got jaundice or not. If they look anaemic. I don't honestly believe that you can make that sort of a judgement on an email*

> *conversation … just what they smell like, has this patient got ketoacidosis? Are they diabetic, going into a coma? As simple as that. Or, gosh they're not very well washed now are they, they're not looking after themselves.* (James)

Cynthia, the pharmacist who worked in the new amalgamated pharmacy located next door to both the general practices, also believes that it is the patients' desire to "see a doctor" which is key to them not liking the new model of care:

> *They can't see a doctor, they can't see <u>their</u> doctor, either/or. So they can ring up in the morning and there's no appointments. The nurse can triage, but they can't see a doctor. They want to see a doctor, and they want to see <u>their</u> doctor, because traditionally they've always seen <u>their</u> doctor. And okay, that part's got to change, but I think they would like to see their doctor occasionally. You know, say once every two or three visits it would be nice to see their doctor, because that's the person they've formed a relationship with.* (Cynthia)

Cynthia believes this lack of consistent care from one doctor does have an impact on patient care: "No doctor prescribes the same way, and so you might get changes along the way and it's very unsettling for them. So the bottom line is they've lost the patient focus" (Cynthia). Like James, Cynthia believes that patients are voting with their feet and increasingly moving across to the Family Medicine Practice. She explains: "they can ring and get an appointment with a doctor. That might be only 5 minutes, it may not be a quality appointment, it may not be done the same way as the other surgery, but they'll get into that surgery and see a doctor" (Cynthia).

7.6.3.3 The hospital corridor

As the DHB and Orange PHO implemented their re-location of the new pharmacy and general practices to the refurbished wards, a number of providers ended up being co-located along the hospital corridor: laboratory testing, hospital and community physiotherapy services, Plunket, mirimiri[22] massage run by the local iwi-provider, the midwifery service, a podiatry clinic, and some of the community services of the Pacific provider. The DHB and Orange PHO believed that this co-location would gradually lead to more integration and better collaboration amongst providers and practitioners.

This is not the experience of Elsa, has an office in the hospital corridor quite close to the two general practices. Elsa thinks the new model of care has had an impact on her ability to collaborate with practitioners in the new general practice. Now that the GP is not central

[22] A traditional Māori form of massage.

to the way they operate, she thinks that it has been harder for Orange PHO to make a permanent appointment of a GP. Consequently, there has been a pattern of many temporary locum GPs[23] being appointed. She explains that people like her who are outside the general practice need to build relationships with new staff in order to collaborate:

> *They've had a lot of locum GPs. So I have really good-- so with some of the GP's that are established I have, you know, good relationships with. The ones that are more locum that I haven't been across to meet, then, you know, you know sometimes it's the communication thing, of you know, getting to find out if the patient's been in to see the GP, and what the plans are, and you know just keeping in that loop really.* (Elsa)

Further complexities on co-location in the hospital corridor are explored in the following chapter. The narrative analysis shows overall that the situation is complex with practitioners sometimes describing benefits to their co-located proximity, and sometimes noting this proximity has had little impact on collaboration.

7.6.3.4 The electronic referral (a.k.a the e-referral)

The e-referral is a system that is centralised through the district's DHB who operate administratively from a large distant city: "everything is done through the e-referral system." Claire has found that the implementation of this system has had a negative impact on the importance and convenience of the local interpersonal relationships she has with practitioners from other providers. Claire explains what happens with the process which is begun by completing the e-referral on-line:

> *It has to be assessed by the e-referral person in* [name of distant large city]. *They decide if it's got merit. Then it gets sent again to the appropriate-- we do that for everything, for our district nurses, for our physio, for home help, for geriatric assessment. All that stuff is done electronically.* (Claire).

Additionally, Claire comments, though it was designed to streamline services, "in reality what it's done is make the timeframes longer before people get anything" (Claire).

[23] A locum GP in New Zealand is temporarily employed on a short-term contract. Typically these positions will be covering permanent positions when a GP is on leave, or being filling a vacancy until a permanent position is filled.

7.6.4 Metaphors utilised in the narratives

7.6.4.1 Personal distancing metaphors

As Georgia and James contrast the new model of care with the model of care being implemented by the Family Medicine Practice, they stress their view of the importance of the relationship between the patient and the GP utilising a range of metaphors. For example Georgia emphasises the lack of a personal relationship with someone who is known to the patient by using phrases like "you can't have *your* doctor", and "they're *afforded* an appointment, and they don't know if it's going to be with a nurse, with a physician's assistant, or with a doctor" (Georgia).

7.6.4.2 Connecting with people metaphors

The narrators convey a sense of distancing and de-personalising processes when they talk about their frustrations with being forced to carry out e-referrals: "everything has to go through the e-referral system"; "all that stuff is done electronically" (Claire). This contrasts with the language they use to describe their preferred face-to-face engagement with professionals in other services whom they know: "we can't just wander across the corridor"; the podiatrist "pops in".

7.6.5 Values

7.6.5.1 Traditional family medicine

The co-owners of the Family Medicine Practice attach much significance to their way of operating: "We call our practice traditional family medicine, we've got that written on our notice board, and we kind of like that" (James). This valuing of the *traditional* lay at the heart of their resistance to be amalgamated into the new general practice and, particularly, to resist adopting the new model of care. Analysis of the texts identifies three significant values in relation to this stance: the GP needs to be at the centre of PHC; local long-term relationships with colleagues and the community are essential for good practice; the general practice needs to continue to operate as an independent business.

The narrators Georgia, James and Cynthia believe that people in their community prefer the older, traditional model of PHC care being implemented at the Family Medicine Practice. Patients want to make an appointment with a doctor who is known to them, and with whom they have a long-term relationship: "you can choose who you see, and you've

got that continuation, you've got that trust, you've built up that relationship … although Family Medicine Practice is a business, it's a family business, you know, that's the essence of it really" (James).

This valuing of a key, long-term relationship with your own doctor is not present in the new model of care of Orange PHO. Instead, Georgia notes, people have "to tell their story again and again and again. And who wants to do that?" Georgia, James and Cynthia see this new model of care as impersonal: "there's actually been quite a flood of people coming over from there to the Family Medicine Practice, because they don't like the impersonal" (Georgia). James' identity as a doctor in essence requires him to continue to practice in this way.

> *This is what I was born to do, I was trained to do, I like to think I make a reasonable fist of it. And it's a valuable service to the community ... we care about our patients, it's a caring profession. We want to be able to provide some sort of continuity.* (James)

7.6.5.2 Local long-term relationships between practitioners and the community

Strongly intertwined with the centrality of the doctor to PHC, is the importance of long-term relationships between people seeking health care and practitioners. The narrators place much value on the long-term relationships that practitioners within the Family Medicine Practice have with people in community.

> *I've been here for 32 years and* [name of co-owner]*came-- he's been here for between 30 and 29 years. We've had patients here who-- we used to do maternity, we've delivered their children and their children are now having children.* (James)

Similarly, James goes on to describe the importance of these long-term relationships between the receptionists and their community, noting that in the Family Medicine Practice patients phone up and speak to "the receptionist that they've known for the past 20 years" (James). The GPs and practice nurses use these long-term relationships to provide a better service.

> *Being able to say, "I need to contact this patient, but I can't get hold of them," and you'll go to the receptionist and they'll say, "oh, that's so and so's Aunty, they've gone off to the beach but I know if we call so and so they'll be able to contact them." So that old fashioned and old traditional-- but, networking is great.* (James)

I asked the practice nurse of the Family Medicine Practice how important it is as a practice nurse to build relationships with other professions both in and outside the service. She replied, "Well it is in this practice" and then went on to explain that "it depends on the medical model that the practice follows and the financial model the practice follows, and the culture within the practice" (Claire).

7.6.5.3 General practice independence from the PHO

The third value intertwined with the identity of the Family Medicine Practice and their resistance to amalgamation is their valuing of their organisational independence.

> *We like to retain a significant degree of our independence. But we like to have the support of an organisation behind us such as Green PHO, which is sympathetic towards patients' needs.* (James)

Part of this independence is financial ownership of the Family Medicine Practice by James and his co-owner, another GP. To become a part of the new general practice that was being set up by Orange PHO, the Family Medicine Practice would have had to sell their ownership, something they were not prepared to do. At the time of the interviews for this study James and his co-owner GP colleague were attempting to recruit two new GPs whom they wanted to "buy into the practice". They were finding this difficult as younger GPs increasingly do not want to take on the responsibilities of running a business. James' explanation on why he and his co-owner colleague are persevering with this ownership model highlights how he sees the relationship between PHC and a small business:

> *It would be good if they did, for several reasons: one financially, obviously; two, they're going to be motivated when their earnings are dependent on the running of the practice and the efficiency of the practice, and the financial state of the practice.* (James)

7.7 Overview of analysis of narratives at Site Two

In a similar way to Site One, this narrative analysis paints a clear picture of the significant effort people outside of the general practice put into developing collaborative practice relationships. This involves closing gaps between hospital care, home-based care, hospital-situated community clinics and the general practice. The information and communication systems that lie at the centre of care (like lab results, patient notes and hospital discharge letters) serve to maintain the locus of PHC at the general practice, in spite

of the amount of PHC that happens elsewhere. The significance of this place of care is picked up in analysis of the following chapter.

A further important thread of the narrative analysis at Site Two was the ways that organisational systems have interfered with the establishment and maintenance of cross-organisation collaboration. The DHB, Orange PHO, the owners of the original four general practices, the Pacific provider and the iwi provider in the small provincial town could not find a way to create one clear integrated PHC system in the town. Instead, each of the general practices (one new amalgamated one; alongside the enduring Family Medicine Practice) aligned themselves to two different PHOs that operate in the small town. Intersections between the iwi provider and the rest of PHC were identified as tied to short-term contracts and not built into the infrastructure.

7.8 Conclusion

PHC funding, alongside established clinical information systems, has situated the general practice at the centre of care-coordination and care integration. However, this narrative analysis shows that practitioners outside of the general practice do not see the GP as quite so pivotal in care-coordination, care integration and ICP. Instead, practitioners working outside of general practices find themselves fulfilling these roles. In spite of the policy and funding systems being founded on the premise that general practices provide care coordination, care integration, and continuity of care, in reality it is practitioners outside of general practices working hard to ensure that their work in these areas is understood and documented within the systems of the general practice.

This continued dominance of the general practice is considered further in the next chapter which analyses the place of PHC with regard to people's homes, the pharmacy, and the general practice. Strongly connected to this consideration of place in the following chapter is the significance of time scarcity in the general practice, which featured in four of the five narratives in this chapter. All the practitioners accepted the constraints placed on ICP as a consequence of these 10-minute appointments. Practitioners outside of the general practice invested more time in ICP as a consequence of this time scarcity, in order to improve the care that people receive in PHC. Commonly it was noted that funding of these practitioners outside of the general practice did not cover this investment of time in building and maintaining relationships between practitioners of different providers.

In spite of the continued dominance of the general practice in implementing PHC, the potential for PHOs to influence PHC is visible across the narratives. This is especially visible in the roles the PHOs play in facilitating ICP across organisations. In Assemblage One the PHO is integral to setting up the Gout Project. In Assemblage Three the PHO establishes the Wellbeing Support Team and takes a leadership role in facilitating a solution to the referral problem. Finally, Orange PHO takes a lead role in working with the DHB to implement the new PHC infrastructure across the provincial town.

There are strong tensions between the publicly funded systems of PHC and the private-for-profit systems. In particular, pharmacies and general practices operate as for-profit organisations. This interferes with them investing time in developing strong relationships with practitioners outside of their business. These tensions have informed the discourse analysis which is laid out in more detail in Chapter Nine.

Chapter 8 – Considerations of place and interprofessional collaborative practice

8.1 Introduction

There are strong connections between people, their health, and place. Kearns & Gesler (1998) argue that "quality of life is produced in and by the places that encircle people, whether they be housing environments, residential neighbourhoods, or the complex of land, people, and material interventions that make up regions" (p.292). In this chapter I examine ICP in PHC by considering the intersections between the places where PHC happens and the relationships between these places and the people who provide PHC. It was argued in Chapter Two (Section 2.7.1) that it is important to consider ICP within its cultural and organisational contexts. In this chapter these aspects are considered through the lens of the places of ICP in PHC. The places that were most visible in this study were the general practice, the pharmacy, and people's homes. Attention to these places is informed by a geography of health perspective.

> Places are more than locations, they are recognized as complex social phenomena with which individuals and groups develop attachments, identity and associations, and attribute meaning and significance. (Lapum, Chen, Peterson, Leung, & Andrews, 2016, p.131)

In Aotearoa/New Zealand the relationships between these places and the primary care services operating in these places has long been recognised as important (Crooks & Andrews, 2016; Kearns & Neuwelt, 2016). This acknowledgement of place in PHC was reinforced in Aotearoa /New Zealand with the release of the 2001 PHC Strategy (King, 2000). As noted in Chapter Six the PHC Strategy is strongly informed by the Alma-Ata definition of PHC. The significance of place is visible in the second part of this definition, which is cited in the PHC Strategy:

> [PHC] is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (p.29)

8.2 The place of the general practice in ICP

This section considers the relationships between the place of the general practice and the ICP relationships with different practitioners both in and outside the general practice. Nine of the twenty research participants requested their interviews be held within a general practice. Visits to these four general practices provided an opportunity to make field observations drawing upon the *Space, Place and Time – Fieldwork Observations Framework* established early in the study. Analysis of these observations, alongside the narrative analysis of Chapter Seven sheds some light on relationships between the place of the general practices and ICP. Key features of the general practices that inform this analysis are summarised in Table 16.

Although there were a number of unique features in each of the four general practices I visited, they held the following in common. They were located in close proximity to places of high community activity (e.g. suburban shopping centres, marae, a hospital, and a school) and this locality featured in their explanations of ICP. Practitioners other than doctors were less visible than doctors in signage. Upon entry to each general practice, the first contact is with receptionists at a reception desk. Although no receptionists were interviewed in this research study, the role of the receptionist in ICP was named as important by practice nurses and GPs. None of these four general practices had a pharmacist on site, though pharmacies were in close proximity to all four general practices visited.

In this section, I consider these features in three sub-sections: the significance of the community locality of the general practices; the hospital on-site locality of the Family Medicine Practice at Site Two; and finally the place of practitioners who are neither GPs nor practice nurses within the general practice. In Section 8.3 of this chapter the place of the pharmacy is discussed.

Table 19

Contexts of practitioners within general practices

	Site One		Site Two	
	General practice One	General practice Two	General practice Three	General practice Four
Identifies as:	Medical centre	Integrated Family Health Centre (IFHC)	Traditional family medicine practice	General practice and family doctors
Includes practitioners other than GPs and practice nurses	Social Worker	Podiatrist Physiotherapist (Social Worker recruited during data collection)	None	None
Owned /managed by	Owned by Green Cross[24] Managed by a non-clinical practice manager	Owners/managers are a husband (physiotherapist) and wife (GP) and one other doctor	Owners/managers are two GPs	Owned by three GPs Managed by a non-clinical practice manager
Located in	In a suburb with high social deprivation in a provincial town Adjacent to a suburban shopping centre containing a supermarket, a pharmacist, a number of food outlets, clothing retailers and other small businesses	In a suburb with high social deprivation in a provincial town Adjacent to a collection of neighbourhood street corner shops (including food outlets and a small dispensing pharmacy) A school and marae are nearby	Purpose-built premises on a hospital site in a locality where other PHC providers and practitioners are co-located (though operate independently)	A very small provincial town serving a rural community The sole general practice in this town.
Interviewed (site of interview)	Mary - practice manager (open shared administrative space) Tina - clinical nurse leader (clinic room) Denise - social worker (clinic room)	Lisa - GP owner/manager Josie - practice nurse Adele - podiatrist (all interviewed in clinic rooms of the IFHC)	James - GP co-owner/manager (home) Claire - practice nurse (clinic room)	Tracey - practice manager (administrative office)

[24] A large for-profit company owning multiple general practices, pharmacies and other health services across the country.

8.2.1 The community locality of the general practices

Practitioners who worked in general practices spoke about the significance of their premises being situated within the community they were providing PHC services for. The importance of this aspect of place in PHC has been discussed by Andrews and Crooks (2016) who note that practitioners:

> Are not only physically co-present with patients, by the fact that they have offices which are local, but also that they practice in the same community and environment in which their patients live and work. Further, their offices are often a visible part of the community. (2016, p.116)

These connections to place and community were woven into the ways that all of the practitioners who work within the general practices spoke about their collaborative relationships with other practitioners and providers. Three sets of stories particularly signify this importance. Lisa described the relationship between the collaborative relationships between the IFHC and their local community. Tina spoke about the influences on ICP between practitioners from a range of providers in their suburb as a result of getting to know each other at regular meetings of a local community network. Finally, Claire and James of the Family Medicine Practice related a number of stories signifying the importance of them living and working in their local community for 30 years.

The significance of the community locality of the IFHC featured in several stories told by Lisa beginning with how she and the co-owners of the IFHC decided where they would build their premises. After researching the needs of the community they decided on their site based on four factors: the high levels of social deprivation of the local community; the area was under-served by general practices; the presence of a number of social institutions including a marae and several schools that the IFHC anticipated having useful working relationships with; and Lisa noting she and her husband had relatives in the community as well as wider cultural connections which led them "to want better for this community". This desire to *want more* for this community has continued to influence their attention to building collaborative relationships between the IFHC and the community.

Lisa described her relationship with the local school and marae as "community partners" with whom they had collectively developed a programme to improve the health and wellbeing of children and youth in the local community. She also discussed the efforts that the IFHC had been putting into their long-term relationships with the Māori health

provider of the local iwi, commenting that these kinds of collaborative relationships with different groups take time to build:

> *We're only now kind of talking about formalised MOUs[25] and collective projects. It took-- it's taken a couple of years of working togeth-- just working with each other and backwards and forwards to actually know what our collectivism might look like.* (Lisa)

Lisa expressed some concern that it had taken a long time to get to this place of being able to envision this collaborative relationship. She partially attributed this to the busyness of being a GP. However, she also recognised the importance of the two organisations getting to know each other:

> *I think sometimes that if you rush into them* [MOUs and collective projects] *you can end up being disappointed down the track. Or finding that what you initially thought things were all about, it may not be like that. But I think given time you understand what each other's priorities are more.* (Lisa)

Their community locality has also affected their employment decisions. Lisa told a story about deliberately recruiting a staff member who was a local to strengthen the collaborative relationship between the IFHC and the local community: "they're part of this community and growing up very much in an environment that a lot of our patients have grown up in". When concerns were raised about the quality of work of this person, knowing she was a local changed the way the co-owners/managers of the IFHC responded to the concerns. The practice management team had begun the process to exit this person from the IFHC, but Lisa recalls their decision to work with her to help raise her performance.

> *If we exited every person that wasn't as qualified or as smart as what we would expect in a role, then we'd be doing a dis-service to this community because actually for having people who've grown up within this community, and experienced the same challenges as people that we see day to day within our patient population, that gives us more connectedness and understanding of who they are and what they have to struggle with.*

Committing to working through the employer/employee relationship became another way to consider the collaborative relationship between the IFHC and their local community.

The second set of stories shedding light on community locality of the general practice and ICP were those in Narrative One. John, Mary and Tina relayed their experiences of moving past relationship difficulties between John's pharmacy and the Medical Centre

[25] MOU - memorandum of understanding.

where Mary and Tina work. Analysis of their ability to develop stronger ICP signals three things were at play: John's perseverance with the relationship; the appointment of Mary as a new manager of the Medical Centre who brought to bear her problem-solving stance; and the relationships between these parties at regular local community networking meetings.

Lisa at the IFHC was named as a key organiser of these networking events which involved practitioners from a range of social service and health providers who would meet regularly to discuss "what do we need to do for the community?" (Tina). The providers who attended included the two general practices involved in this study at Site One, as well as several other general practices from those neighbourhoods. The two pharmacies at Site One also attended, as well as people from the local schools, the local marae, the iwi provider and several other social service organisations. Relationships between practitioners and providers were positively influenced through these meetings.

The nurse clinical leader, Tina, at the Medical Centre occasionally attended these community meetings when the practice manager, Mary, was unable to attend. As relayed in Narrative One, in Section 7.2.5, Tina believes that seeing John at these meetings was an important part of her being less reactive to John's attendance at the Medical Centre fortnightly staff meetings. For Tina, seeing him at the community meetings was key to this change. Tina reflects that part of this shift was being prepared to listen to him.

> *I think I listened to him more at these other outside meetings. So, he wasn't in my patch, I suppose, and so I could listen in a different way maybe? Because I thought, "oh, you've got a lot to offer".*

The third set of stories in this section on the importance of general practice community locality to ICP were situated in Narrative Four. James (GP) and Claire (practice nurse) highlighted the significance of living and working in their local community for 30 years. They were well-known by members of their community and in turn knew community members. James identified these long-term relationships as contributing significantly to the ICP between himself and practitioners in several hospital departments, including Radiology and Emergency.

Claire also spoke of the importance of these long-term relationships in community, relaying stories of serendipitous encounters with other health practitioners in the community that contributed to ICP. For instance, Claire had referred one of her patients to the meals-on-wheels service provided by the hospital. Later, whilst shopping in her local supermarket at

the end of her work day, she saw a person from this service that she had known for a long time. They chat and during the conversation, Claire is told by this practitioner, "yes, we went around there" (Claire).

8.2.2 The hospital site location of the Traditional Family Medicine Practice

Narrative four in Chapter Seven considered some key aspects of collaboration in relation to the Family Medicine Practice being re-located to the re-furbished hospital wards. This move was partially motivated by the expectations of the DHB and Orange PHO who anticipated this co-location would lead to better integration and increased ICP. James also anticipated potential benefits from co-location with the pharmacy and laboratory testing services. The reality of the potential benefits is quite complex with both James and Claire variously considering how this helps or not.

Claire identified some benefits of proximity to the new pharmacy noting it was now particularly easy for the pharmacist to call into the Family Medicine Practice to clarify prescription concerns and access needed resources: "If there's been a mistake, or they think a script's not right, they'll walk over here, sit down and wait for the doctor and say, 'what's this?'" Similarly, Claire herself found it easy to visit the pharmacy.

> *They either wander in here or we wander over there. I can wander over there, go behind the counter and say, "*[pharmacist's name] *can you fix this for me?" Or, whatever. Or "have you got some of this?" or "can you get it?"* (Claire).

Claire noted that these kinds of interactions happened daily. The pharmacist, Cynthia also found the proximity to the two general practices to be a positive experience: "I felt quite comfortable bowling into either surgery[26] or down to A&E and talking to the doctors down there".

Upon further reflection on the nature of this relationship with the pharmacy, however, Claire explained that prior to the move to the refurbished ward, the pharmacy and the Family Medicine Practice were in close proximity in the town centre and had worked closely with each other for some time: "they were just on the other side of the street, we just had to walk across the street." It may well be that their long history of working in the same town was more important to their ICP than the co-location in the new premises at the hospital.

[26] A GP practice is also commonly called a surgery in Aotearoa/New Zealand.

Claire also described a positive collaborative relationship between the Family Medicine Practice and the co-located podiatry service. Claire attributes this positive relationship to the podiatry people having a room within the Family Medicine Practice: "they come here, and we refer patients, so I don't have to have a doctor's permission to do that, I can do my own referrals". Upon analysis, it is not so clear that physical proximity is the main factor at play. As James reflects on this collaborative relationship, he notes there is a family relationship between the podiatrist and one of the co-owners of the Family Medicine Practice so he "pops in and has a coffee and things like that."

When I pressed Claire to make a judgement on whether the hospital corridor helps with collaborative relationships or not, she concludes: "It makes no, it doesn't make any difference to it, to be perfectly honest". She goes on to explain this conclusion by noting that any positive contributions from close proximity in the hospital corridor are undermined by the distancing processes of the e-referral process that all practitioners within the DHB are required to use. Though, having mostly negated the potential benefits of co-location, it appears there are some 'work-arounds' with regard to e-referrals. Claire and James both talk about their good working relationship with the district nurses, who are co-located in the hospital corridor: "We have good rapport and we interface quite well with that. They'll phone up and say, "look, so and so is really not doing too well"… so we'll go down have a look, we'll discuss it with them" (James).

Nevertheless, Claire finds the DHB implementation of e-referrals mostly interferes with her ability to liaise informally with practitioners, as in this experience with the co-located physiotherapists:

> *We can't just wander across the corridor and say, "look I've got this lady" – and I tried it once, it didn't work. She's got a terrible problem at home, she was falling over all the time, "she needs a walker, can I?" Well, no! I had to do an e-referral, to go through there. And so in actual fact we have very little to do with them* [the physiotherapists]. (Claire)

This disjuncture with the physiotherapists was reinforced by James who noted: "we hardly ever really have that much contact with them, it's really just through e-referral" (James). In spite of this, James thinks there may be benefits of seeing people in the corridor:

> *I think it's probably improved the relationships, in-- just the proximity. Inevitably. You walk past people and say 'hello', you know who they are, you remember who they are, and it's more in the forefront of your mind rather than in the back of your mind, I would say.*

James also sees the co-location as benefitting an easier transition from PHC into hospital-based services like the emergency department. He describes several situations where he phones the doctors at Accident and Emergency or X-ray people to expedite this transition:

> *We'd really like your help here, I think they need x-rays, they need an ECG because they've got chest pain and blood tests, and they say, "go ahead" and the nurse will put them in a wheelchair, wheel them 200 metres down the corridor, well 250 metres, and they're there, you know. I'll have done a little referral letter that goes down with them.*

However, it is not clear how much the proximity to the emergency department via the hospital corridor facilitates this access to care, and how much this, too, is influenced by previous relationships with the professionals in these services.

> *We know most of the doctors, in particular, and also nursing staff, who work at A & E, because we've all been there* [in the town] *for a long time and a lot of the nursing staff have been there for a long time.* (James)

Indeed, he names some people noting that they have been long-term patients of the Family Medicine Practice.

As the pharmacist, Cynthia, concluded her final reflections on the potential contributions of co-location to ICP she is mostly positive about the co-location as it has resulted in "all the resources in one place for Joe Public to access" (Cynthia). Nevertheless, she too critically reflects on the co-location:

> *You can't just pop four buildings together without taking the people factor into account. I don't think the PHO would have thought about that. They just saw it as convenient for the patient, because the set up at [the new premises] is not in the town centre. So, they wanted all the resources in one place for Joe Public to be able to access everything. And they've done well, everything is there.* (Cynthia)

She is clear, though, that co-location does not automatically lead to better ICP. Rather, Cynthia argues that work has to be done to build relationships between professionals in the different organisations: "the relationship, yeah, it has to be fostered, and a bit like respect, it has to be earned."

8.2.3 The place of particular practitioners within the general practice

The site visits to the general practices in this study provided a glimpse into the dominant place of the GP compared to the place of the practice nurse. Additionally, two of the four general practices visited had practitioners other than GPs and practice nurses working within their premises. In this section the place within the general practice of practice nurses, receptionists, podiatrists, a physiotherapist, and a social worker are considered.

8.2.3.1 The place of nursing in the general practice

McInnes, Peters, Bonney & Halcomb (2015) argue there is little evidence to explain how GPs and practice nurses collaborate, or indeed, how they understand what collaborative practice is. My consideration of the place of nursing in general practices sheds light on some aspects of this understanding of collaborative practice. All four general practices named the presence of GPs in their street/building signage. In contrast, nurses were not named in the signage of any of the general practices, though it is clear from the data that the role of the practice nurse is crucial to the work in the general practice.

The GPs identified the importance of practice nurses to their work, naming particularly their ability to spend more time with patients than the GP: “We’ve got 10-minute appointments. We’re seeing 25 to 30 patients plus, per day. Each. And the nurses do a lot of triage for us” (James). In addition to this triage performed by practice nurses prior to patients visiting GPs, the practice nurses spoke about the work they did with patients once they had left their appointment with the GP: “Ten minutes, he had his appointments, and they would literally come out of the door and they would come into my room to get the rest of the consultation that they didn’t get with him” (Tina). Both the GPs and the practice nurses agreed that this means the nurses build better relationships with the people seeking care than do the doctors.

The proximity between the GP’s and nurse’s rooms was noted as important to enable professional interactions by both GPs and practice nurses. Tina describes the set-up at the Medical Centre where there are two doctors and two nurses: “All four were right by each other. And they were much-- they would talk much more, so there would be a lot more communication going on, so they already had that little bit of trust happening”.

At Site Two, James, too noted the importance of proximity:

> *It's just the closeness, that fact that the nurses are just outside, you know about 5 metres outside the door to my consulting room, and the reception staff are about 8 meters up that way* [pointing in the other direction]. *You know you're literally seeing each other every time I go out to get a new patient.*

Proximity alone, however, is not enough to develop a collaborative working relationship. The historical hierarchical relationship between GPs and practice nurses was identified by both GPs and nurses as a possible barrier: "'I'm the doctor, and you're the nurse' is not good. It doesn't make people feel good and it makes people lose confidence in their own abilities" (Lisa). Kevin, the GP at the iwi provider, described his decision to leave his general practice position due to the persistence of this hierarchy:

> *General practice is typically hierarchical, GP at the top, nurse underneath, and their practices* [the nurses] *in a very subordinate role. Bringing patients through to see the GP. Not working on their own. 90% of primary care nurses are females; having to run everything past the doctor.*

Previously in Chapter Seven (Section 7.3.5.3) Kevin had very different, much more collegial relationships with nurses at the iwi provider.

Analysis of the texts showed GPs and practice nurses described a gradual movement away from this historic hierarchy in general practices, thus creating more opportunities for ICP. The situation is not clear, however, with the perception that nurses have more time meaning GPs increasingly delegate/transfer tasks and roles to them and this is not always identified as collaboration. This process has been supported by changes that now fund some nurse interactions with patients, that were previously only funded if carried out by a GP. Reflecting on the relationship between GPs and practice nurses at the Medical Centre, Lisa notes, "there's still the hierarchy in some places. It's not so bad here" (Lisa). She believes there is more "sharing of care and knowledge and each side talking, doctors and nurses" (Lisa).

With GPs perceived as time-poor, alongside acceptance of practice nurses picking up more patient care, people external to the general practice are seeing the practice nurse as the most meaningful person to develop a collaborative relationship with. The practice nurse is seen to have the most relevant knowledge about patient care, but also is more contactable than the GP. Practitioners outside of the general practice expressed a desire to collaborate more with GPs but often saw this as futile.

8.2.3.2 The place of receptionists in the general practice

The important place of the receptionist in PHC has been explored by Neuwelt, Kearns and Cairns (2016) who noted that receptionists have a "substantial influence on patients' experience of health care" (p.122). At the Family Medicine Practice James identifies the importance of their receptionists being from the same community as the practitioners and the patients noting "everybody lives in town". James provides an example of the way this long-term, local relationship can contribute to care:

> *Being able to say, "I need to contact this patient, but I can't get hold of them" and you'll go to the receptionist and they'll say "oh, that's so and so's Aunty, they've gone off to the beach, but I know if we call so and so they'll be able to contact them."*

An understanding of the intersections between the work of GPs, nurses, and receptionists was also articulated by the two practice managers interviewed. At the Medical Centre of Site One Mary includes receptionists in the term admin and here describes how they fit into the change management programme she implemented:

> *When I first started here, we met weekly, all the sta—well, all the clinical staff, plus admin, you know a couple of the admin at a time. Just because there had been a lot of change, and we felt-- well I felt, that we needed to have people in the same room to be able to start moving forward.* (Mary)

Mary had a vision that admin were an equal part of the team in the Medical Centre: "I think you can become compartmentalised - that, actually, from the doctors' perspective, 'this is what's important', but they-- actually without any thought or consideration to how it actually flows across the practice" (Mary). The regular fortnightly meetings she implemented were set up to get doctors, nurses and admin to think outside of their own way of seeing actions:

> *There are challenges that are faced at each level and an acknowledgement by any of those groups of people, just helps to make it flow better, and there's better understanding or better teamwork that happens as a result of that.* (Mary)

Tracey, the practice manager of general practice Four in Site Two, took a similar approach to describing the ways she works to bring the different groups of professions within the general practice together into one team. As she described the collection of staff within her general practice she began by naming four teams: doctors, nurses, receptionists, and administration staff (including herself as practice manager in this last group). Then Tracey went on to note:

But I don't see them as individual teams, I see them as one team, because none of the teams can survive without the other… the front staff can't do the nursing role, the nursing staff can't do the doctors' roles, and the doctors can't do the administration roles. So, no team can survive without the other teams, and so no team is more important than another part of that team.

8.2.3.3 The place of the podiatrist and the physiotherapist in the IFHC

The IFHC (general practice Two) at Site One was one of the two sites visited during data collection which signalled the presence of a podiatrist through signage. The other site was the clinical centre located on the hospital grounds of Site Two where the Traditional Family Medicine Practice was located. The IFHC signage was unique, however, as the signalling of the presence of a physiotherapist and a podiatrist was given equal weight to the presence of the doctor, appearing on their building sign underneath the name of the IFHC itself in the same font and font size (see Figure 11).

Figure 11

Representation of signage at the IFHC

Whereas, at Site Two the signs for the physiotherapist and podiatrist were completely separate from the signage of the Traditional Family Medicine Practice.

As Lisa reflected on the original plans for the establishment of the IFHC, she noted that initially they had planned to incorporate a pharmacist into their business model. Ultimately, they did not proceed with this plan as there were two pharmacies close by. Inclusion of the physiotherapist and the podiatrist into the IFHC, however, remained key to the model. Lisa believes that her husband being a physiotherapist has influenced her stance towards allied health professionals and has, challenged her thinking and reined-in her doctor's viewpoint: "you know the god complex is real, in general, with doctors. As such, my husband has always kept me humble in terms of my humanness, and shortcomings" (Lisa). For Lisa, this has influenced her preparedness to engage collaboratively with other allied health professionals: "I've always seen benefit in what allied health brings, umm to health as a whole."

This stance, she believes, influenced her work with Adele, the podiatrist, prior to setting up the IFHC. Lisa had worked closely with Adele in a previous role, thereby coming to highly value podiatrists: "I had done some work within an iwi provider, quite closely with her and she was interested in being more connected… I see them as a specialist for feet basically, and their whole degree is around feet and bio-mechanics and walking and stuff like that and that-- I've never had that in-depth" (Lisa). Thus, when it came time to work with funders and the local PHO to establish the IFHC Lisa was clear they needed to incorporate a podiatrist. Additionally, that having allied health professionals present on the premises needed to be more than co-location: "I said, to the PHO, it's not-- we will not be just co-located, our -- the point of us doing an integrated family health centre is actually having the collaboration, not just the co-location" (Lisa).

Adele herself had put much work into establishing working relationships with GPs in the district when she first began practice there. This is unusual for podiatrists, she noted, as it is more common for them to be working in isolation and not connected to GPs, an approach she didn't like: "I came up here and immediately started working with GPs. I was just in their face, 'you need to use me'" (Adele). Adele's stories illustrated that collaboration with other practitioners in the IFHC had become their way of practising. She highlighted the importance of her relationships with the GPs, the physiotherapist and the practice nurses, describing this "collegiality" as contributing to her being "safer in practice" (Adele).

> *More so here, than anywhere else, is if I'm seeing something in clinic, that I am unsure of, concerned about, I can always go get another set of eyes from a different perspective and that is phenomenal. The things that we've picked up on together, that we had, or could have missed.* (Adele)

Lisa also named the importance of this collaborative relationship with the podiatrist, suggesting that their trusting relationship combined with co-location was key: "if she had her offices over there and she was completely separate with her business model, and her computer system was completely separate from ours, I don't think we would have that same relationship" (Lisa). Proximity to each other, combined with the trusting relationship built up over time enables collaborative practice: "I can see notes that she has done on patients that I see. And she can see my assessment, or we can have conversations in the lunch room" (Lisa).

The practice nurse at the IFHC, Josie, did not convey quite such a strong sense of collaborative practice with the physiotherapist and the podiatrist. She described her working

relationships with the physiotherapist and the podiatrist who were located in the IFHC as very similar to those with podiatrists and physiotherapists located in other providers. Electronic referrals defined both sets of relationships, though she noted that with the physiotherapist and podiatrist on site the practice nurses would commonly go a little further and, "tell them what we've done, just add a bit more, because we have that opportunity" (Josie).

8.3 The place of the pharmacy in ICP

The contributions of pharmacies and pharmacists to PHC has been identified as important in assisting with responses to the challenges of workforce shortages, ageing populations and the increasing incidence of LTCs. Indeed, there is a growing body of literature demonstrating multiple benefits to integrating pharmacists into general practices (Kelly et al., 2013). In this study none of the four general practices visited had a pharmacist working on their premises. All had a pharmacy, however, within very close proximity to their site.

In this study, the proximity of the pharmacies and general practices has three strong connections to ICP. First, like general practices, pharmacies are located close to where people live, work, and carry out other community activities. Sharing a common locality raises potential for a range of collaborative connections between pharmacies and general practices. Second, pharmacies are identified as a site of PHC provision. People will seek care from a pharmacy instead of going to a general practice, or in connection to a general practice visit. Third, strongly connected to the above two points, there are strong interdependencies between the PHC that happens in the pharmacy and the PHC that happens in the general practice. This study shows, however, that pharmacists bear the burden of building and consolidating interdependencies.

8.3.1 The community locality of the pharmacy

Like general practices, pharmacies operate as for-profit organisations established on commercial principles, thus they pay close attention to income-generating and cost-reducing activities[27]. Yet, at the same time, pharmacies are situated within community contexts and recognise their responsibilities to provide care to people in their communities. The interplay

[27] It is noted that some pharmacies (like Pharmacy Two in this study) operate more exclusively as dispensaries; though they usually still sell products, these commercial aspects are less important to their core modus operandi.

between these simultaneous accountabilities (business imperatives; community care responsibilities) is discussed in this section with regard to the three pharmacies that featured in this study.

8.3.1.1 Pharmacy One and the Medical Centre

Pharmacy One is a commercial pharmacy selling a wide range of beauty, health, mobility and gift products from large premises in a local suburban shopping centre. These products increase the pharmacy's commercial profile and help to consolidate their place in the community. It is located across a carpark from general practice One, the Medical Centre and approximately a kilometre down the road from Pharmacy Two and general practice Two, the IFHC. Pharmacy One is a family-owned and operated business that has been in its current premises for 30 years. John and his wife (the general manager of the pharmacy), took over the ownership of the business from John's father approximately 20 years prior to data collection in this study. John was a key social actor in the episodes of Narrative One involving both the IFHC and the Medical Centre as described in Chapter Seven, with the proximity of his pharmacy to these two general practices being named as significant in multiple stories told by people in both these general practices.

8.3.1.2 Pharmacy Two and the IFHC

Pharmacy Two is a dispensary-focused pharmacy selling very few commercial products. It is located close to general practice Two, the IFHC, on very small premises in the middle of some corner shops beside a busy suburban intersection. The relationships between the IFHC and the pharmacist, Christine, from Pharmacy Two are very strong. Lisa at the IFHC argued the proximity of Pharmacy Two helped her decide to not include a pharmacist in the IFHC. The close relationship between the pharmacy and the IFHC was confirmed by both the practice nurse of the IFHC, Josie, and Christine. One example is demonstrated in the story later in this chapter of the drug cupboard (Section 8.3.3).

8.3.1.3 Interplay between the two pharmacies and the two general practices

Lisa explains the significance of the proximity of both pharmacies with the two general practices for members of the community:

> *In terms of the urban practice, people can go wherever they want to, you know, so unless, you know, so lots of patients have a pharmacy that's not*

> *necessarily here, but, for-- but the bulk of our patients probably would go to either-- from a convenience perspective, they would go to* [Pharmacy One or Pharmacy Two].

The relationships between general practices and pharmacies are significant in terms of the income security of pharmacies, as pharmacies are funded from Government for dispensing medicines. John and Christine describe themselves as being "in strict competition" with each other. John explained the long history of competition from when his pharmacy first moved from a different suburb into their current premises in the suburban shopping centre. At that time "they [Pharmacy 2] really had the lion's share of the business, and we were very much struggling, and we had no real practice that we were aligned to" (John).

Despite their competition for commercial territory, there is some collaboration between the pharmacies and the IFHC. John attributes this partly to the way the IFHC operates.

> *I mean* [the IFHC] *would be quite a different practice from anyone else in town from the point of view of-- just from-- just that, you know, getting involved, you know, with both pharmacies, you know. Because they're quite involved with Christine there, and do a lot of stuff with Christine, just because she's close. And you know the client base is shared between us, so that's cool. But, and it's actually led to Christine and I having more information together as well.* (John)

8.3.1.4 The significance of community location to the pharmacies

All the pharmacists were clear that the nature of their community locality was important to their ways of operating. In the following example, Christine from Pharmacy Two contrasts the different groups of people in her area compared to one of her colleagues:

> *They are in a completely different area, where there are more Caucasian people, hardly any Asians or Māori people, so their experience is again very different what we have here, cos we're-- most of the time are Polynesian and Māori people and very little Caucasian people, and in terms of financial status, they are much better and so the medication they dispense is again very different to the one that we dispense here.*

The pharmacists noted that they live and work in the same community where their pharmacy is located. Consequently, they become knowledgeable about the history of the community, the organisations and practitioners within it, and the needs of people. Over time,

they accumulate knowledge about who is accessing what kinds of care from the local general practices. For John, this motivates him to spend time with people who access his services:

> *I like to chat and communicate, and I think that's the key to looking after your patients as well. Because we need them to be in a situation where they tell you lots, and… the more we understand about the patient, and if we're talking to other health professionals, what knowledge they've gleaned, and what we've gleaned, it just makes a better picture.*

John's place in his community also motivates him to attend local community meetings. Some of this is about community-consciousness. The people in pharmacies 'name' the significance of being located in particular communities to the work that they do. They highlighted the 'responsibility-to' people in 'their' community; the experience of the history of living in this community over time. They live in the communities they serve; they know these people

8.3.2 The pharmacy as a site of PHC

Pharmacies are sometimes recognised as a site of PHC and pharmacists are often recognised as PHC practitioners. For example, the Ministry of Health notes: "The Government places an emphasis on the broader multidisciplinary PHC team – general practitioners (GPs), nurses, pharmacists, and other health professionals" (2021). An important component of pharmacists' PHC roles is dispensing medications according to prescriptions, and in providing advice to people on how to take that medication as well as educating about the common side effects and contra-indications of the medication. Pharmacists also provide health advice and sell over-the-counter health products for a broad range of minor illnesses and health concerns, for example pain management, first aid, and skin care. Key to their provision of health advice is knowing when to recommend people go to their general practice to consult with a nurse or doctor. Pharmacists also need to phone GPs at different times with regard to various aspects of these roles.

For this reason, pharmacists see great value in establishing trusting relationships with GPs who are nearby their pharmacy. Chapter Seven includes many of John's stories (Pharmacy One) on establishing these relationships. Christine (Pharmacy Two) similarly names the importance of establishing relationships with GPs: "It's quite different when you're talking to someone who you don't know the face of. It's just a job. It's just work. Whereas if you know the face of the doctor, or the pharmacist, when you're talking it's different" (Christine). For Christine this means getting to "know what the person looks like,

what their belief is, and how they work, what their priority is". This enables her to establish a stronger team-like relationship with the general practices which enables Christine to more easily follow-up with GPs when there are problems with 'scripts'.

Christine explained the situation when she first arrived at Pharmacy Two: "With the doctors here, we're just down the road, but we weren't working as a team at all…we do a lot of their patients and we didn't even know what the doctor looked like, or who the manager was, or who we were dealing with at all". This prompted her to initiate contact with the local GPs and meet up with them individually: "we need to know the face of each other, we need to be friends, and we need to re-iterate that we are in the same team, we are not separate" (Christine).

These kinds of trusting relationships are also important for Christine with doctors in other services, like mental health services and the Community Alcohol and Drug Service (CADS) due to role expansion of pharmacists. In this study the pharmacists talked about their relationships with general practices and other health service providers with regard to the following three programmes: dispensing methadone and associated services related to opioid substitution treatment (OST); assisting with the management of gout; and carrying out blood clotting testing under the Community Pharmacy Anticoagulation Management Service (CPAMS)[28]

8.3.2.1 Pharmacist contribution to OST

Christine spoke about dispensing methadone to people through her pharmacy's participation in OST. Patients on this scheme are registered with a doctor from Community Alcohol and Drug Services (CADS) for provision of the methadone prescription, and they are also registered with their own GP for PHC. For this group of people Christine described the particular care required in dispensing medication, requiring knowledge of who the patients are, where they live, from which local GPs hey seek care, and who the doctors are in CADS that manage their care. "For those patients we keep a close eye with any controlled drug scripts that's prescribed by any other doctors" (Christine). She describes a troubling scenario which can emerge:

[28] An explanation of CPAMS by the Pharmaceutical Society of New Zealand. From https://www.psnz.org.nz/Category?Action=View&Category_id=262

> *The GPs would quite often prescribe tramadol[29] or some other controlled drugs, even if they know. So, I think what's happening is the methadone clients nag them and they* [the GPs] *end up giving just little bit, little bit, little bit. So, in those circumstances we don't just follow the GP's instruction we always contact CADS.* (Christine)

Knowing who the GPs in the local area are, and who the prescribing doctors at CADS are enables the pharmacist to take appropriate action and seek support when required.

8.3.2.2 Gout management

The gout project was introduced in Assemblage One (Chapter Seven). Analysis of John's descriptions of the initial implementation of the gout project identify two connections to place: the importance of the local relationships between the PHO, general practices and pharmacies; and the improved collaborative relationships with other local pharmacies. John recalls a local GP being the chair of the PHO clinical committee at the time that a group of PHC practitioners had attended a symposium and heard about this "real quick way to treat gout" (John). The GP drew on his local relationships to pilot the project in their area: "He wanted to develop that. And so, in conjunction with the named pharmacy next door to [his general practice] they, and the PHO pharmacy facilitator[30], they put together sort of a pilot" (John). The fact that the PHO had already been funding the Arthritis Foundation to carry out some education services in their area facilitated the setting up of the pilot. John notes that general practices and pharmacies in other areas "were beating at the door to start the project" but they did not have the existing local connections and were not able to do so.

Once the gout project was underway John outlined several ways that it contributed to improvements in ICP with local general practices and other pharmacies. The gout project created opportunities for John to strengthen and maintain relationships with GPs, for example in relationship to the IFHC: "this gout project that's rolling out at a moment is a biggie. So, we're talking quite intently on those patients" (John). He notes this was resulting in more meaningful conversations leading to better shared care:

> *We were sharing information about, you know, what her* [the GP] *plans for the patient were and things like that. So, there was a lot more information coming out with that. That would have been more forthcoming than just simply getting the script in the door.* (John)

[29] Tramadol (Tramal™) is a synthetic, centrally-acting analgesic for the treatment of moderate to severe pain (https://www.medsafe.govt.nz/profs/puarticles/tramadol.htm)
[30] Pharmacy facilitators are often employed by PHOs to consolidate best practices in prescribing and utilising medicines.

The gout project also created opportunities to strengthen and maintain relationships with other pharmacies/pharmacists. For example, John described his changing relationship with Christine as a result of the Gout Project. He noted that sometimes after visiting the IFHC he would now call in to "have a chat" with Christine:

> *See how she's going with the gout patients and see if she's got any-- cos I'm sort of the pharmacy contact for that for {this district} as such. So, you know you use that just to see how she's going and any other questions and queries about things. So, we've developed more of a relationship over-- in the last sort of seven or eight weeks. Whereas before you know you do get a bit of a thing* (Ph1)

John explained this "bit of a thing": This is the competitive relationship that commonly develops between pharmacists as they compete for income-generating activities.

Christine also commented on the improved relationship with John through the gout project. The gout project also gave her an opportunity to find out more about the Arthritis Foundation and the role of the arthritis educator, which previously she did not know about. The arthritis educator visits on a monthly basis and meets with people enrolled on the gout project as well as with practitioners, including the pharmacists. The connection to the arthritis educator has opened up another channel of ICP for Christine: "I wouldn't have known them if this wasn't around. And so now I know where to go, when we have issues with this particular group of patient" (Christine).

8.3.2.3 INR

Two of the three pharmacists spoke about their collaborative practices in relation to their provision of INR[31] (international normalised ratio) point-of-care testing, carried out for people who are taking a drug called warfarin to control blood clots. A number of community pharmacies in Aotearoa/New Zealand now conduct this testing under a funded scheme called Community Pharmacy Anticoagulation Management Service (CPAMS). Historically, people on warfarin therapy would have been required to go to a laboratory to get their clotting time tested, the results then sent to the person's GP, and finally the general practice liaising with the person. Depending on the test result, the dose of warfarin may need to be adjusted, possibly entailing another visit to the general practice and/or the writing of a new prescription and collection from a pharmacy.

[31] INR explained. From https://www.healthnavigator.org.nz/medicines/w/warfarin-and-inr/

CPAMS offers people on warfarin therapy a more streamlined process, avoiding the multiple trips and complexities of inter-organisational liaison, the burden of which falls primarily upon the patient. Under CPAMS pharmacists collect the blood samples directly from the patients, analyse the results, and directly adjust medication if required. Two of the three pharmacies in this study were implementing CPAMS and the pharmacists spoke passionately about the benefits they could see. They highlighted improved relationships with people seeking care leading to better care provision, and improved collaborative relationships with general practices, as the pharmacist in Site Two explains:

> *I'm passionate about it, because it's just so, so good. It's-- you get the opportunity to be professional and form a relationship like a team with your patients so that they understand what's happening. And they also bring forth their health problems, their health issues at the same time.* (Cynthia)

8.3.3 The interdependence of the pharmacy and the general practice

Rathbone et al. (2016) explore the importance of co-location in their exploration of the collaboration between pharmacists and GPs. They argue "that shared perspectives and trust constructed through regular, face-to-face interaction, embedded by co-location, is essential for successful interprofessional collaboration" between pharmacists and GPs (Rathbone, Mansoor, Krass, Hamrosi, & Aslani, 2016). Analysis of my data confirms the importance of this regular face-to-face interaction. However, it appears the onus for establishing these interactions falls primarily upon the pharmacist. Two sets of interactions between the pharmacist and GPs are explored in this section: maintenance of the general practice drug cupboard, and interactions about prescriptions.

As noted above, an important source of revenue for pharmacies is the fee that they can claim from Government for dispensing medications, which motivates pharmacies to nurture strong relationships with general practices. One mechanism in developing and consolidating this relationship involves the general practice drug cupboard, also known as the medicines supply cupboard. The drug cupboard is a place where some prescription-only medicines are made available for clinicians in the general practice to use in specific circumstances in their provision of care. Medications supplied in this way is on the understanding that they are "for emergency use, for teaching and demonstration purposes, and for provision to certain patient groups where an individual prescription is not practicable" (Pharmaceutical Management Agency, 24 November, 2020). The drug cupboards are stocked by pharmacists under the authority of a medical practitioner supply order. Pharmacists in this study described using their maintenance of the drug cupboard on

the general practice premises as a mechanism for the development and strengthening of collaborative relationships between themselves, GPs, and practice nurses.

Having fully supplied drug cupboards is in the interests of both the general practices and the pharmacies. GPs and practice nurses have immediate access to medicines for carrying out care of patients. Pharmacists see multiple benefits from their maintenance of the drug cupboards, with a fundamental benefit being that they are seen by the professionals in the general practice as a good/helpful pharmacist. Once they are seen as good/helpful, GPs and practice nurses reinforce/encourage their patients to go to that pharmacy to fill their prescriptions, with consequent commercial benefit to that pharmacy.

Pharmacists describe three particular purposes of carrying out these drug cupboard visits to general practices. When they do not have a current working relationship with a GP (e.g. there is a new GP who has begun work at the general practice) they will use these visits as a way to engineer a meeting with the GP. They also use this visit as a way of raising concerns with the GP about 'scripts.' They use this visit as a way of updating the GPs on changes to information about medication costs/availability or new research about efficacy. Finally, they use this as a way of raising clinical concerns about particular people:

> *It's letting the doctors know what's happening, and so its sharing that sort of information as much as the, you know, 'Mrs Smith, I think we should do a renal function check because dah dah dah, you know, because that clinical side.* (John)

John describes a system in his pharmacy where they keep "a little book in the dispensary" where they note the pieces of information that they want to relay to specific GPs in specific general practices. Then they visit these general practices to check their supply cupboard. He describes the use of the 'little book' in tracking this process:

> *Little points that come up, something crops up and you write it down, and there's columns and whoever goes to whichever practice on whatever date, just so as we can tick it and date it, so as we know when we've actually talked to the practice about certain things that are, you know, happening.* (John)

Christine describes a similar process of engaging with the IFHC, her closest general practice, via the supply cupboard: "I come up here[32] every-- maybe twice a week, or three times a week. And we also take care of their medication cupboard, so that's my excuse for

[32] "here": Christine was interviewed in one of the clinic rooms of the IFHC as her pharmacy did not have a room suitable for a research interview

coming up here often" (Christine). She describes the motivations for these visits: "say for example if we have an issue with the script or if we think a customer's not taking the medication right, we just jot it down" (Christine). Christine describes the visit to the IFHC:

> *I come up here, if they are busy I can just look at the cupboard, while I'm waiting and if I see them free I just catch them quickly. And then I can actually get to talk to* [the practice nurse] *who knows pretty much what's going on around here. Or sometimes if I'm lucky I can get hold of the doctor.*

In one instance, John tells a story about one of his pharmacists moving into the neighbourhood where a pharmacy is located and developing a stronger relationship with the local general practice: "We had been looking after their supply cupboard and, you know, a few queries and things. But now, one of my pharmacists actually lives in [that suburb], and she goes to their staff meetings."

In addition to collaboration opportunities inherent in pharmacies maintaining the drug cupboard are those that develop around the prescription (a.k.a. the script). In simple terms the 'script' is used as the primary mechanism for the GP to communicate with the pharmacist about medication. However, analysis of the texts indicate that the script sits at the centre of a complex web of communication, miscommunication, opportunities for communication and potential for building collaborative relationships between the GP, the practice nurse and the pharmacist.

John identifies one motivation for putting time and effort into conversations with GPs about the scripts as preventing future problems with patients and GPs. John also suggests there are financial benefits:

> *You can save more time by having those conversations, one-on-one directly, and having that, than-- than trying to put out the fires when things go wrong further down the track. So, at the end of the day, it is a financial plus, but there's no way of measuring that to any great extent.*

This cross-organisation team approach to care is supported by Lapun et al. (2016) who note, "a team approach augments comprehensive and continuous care by constructing ways that clients can move through the system with ease in the places where they live and work" (p.140). John explains a range of activity that contributes to this team approach:

> *Working together, sharing information and ideas for the-- to improve the health of the patient, with the medical centre there, and even giving information sometimes on our, they'll be asking questions that are not patient specific, but it's about what treatments are available or what's funded, what's*

not, what can we do in this situation?; So giving them general information so as they can help their patients improve their health by some means or another. Look, I mean-- it's you-- one day it was simply trying to find on their Med Tech system for them what was the funded items of certain products or what products to do with vitamins and things like that, cos you to try and find some new meds on MedTech is quite like a-- it's a beast of a thing.

8.4 The place of people's homes in ICP

There are a number of important connections made in the texts between interprofessional collaborative practice and the homes of people/patients. Home is identified as a place which helps keep people well, but it can also be a contributor to, or source of, sickness. Although home can be a place that is separated from PHC services (particularly that provided by general practices), home can also be the site of PHC service provision, particularly that provided by community-based not-for-profit organisations. This situation necessitates collaboration between multiple providers of services who often work in different organisations. The burden for establishing and maintaining this collaboration appears to fall disproportionately upon practitioners who do not work in general practices.

8.4.1 Home as a social determinant of health

Practitioners working within general practices identified the importance of having knowledge about the home environments of people/patients, and yet not having easy access to this knowledge. They argue that this knowledge assists them in their diagnoses and treatment plans, and informs their decisions to involve other services in their patients' care. They identify the home as the place which can signal important features of health, health concerns, and understanding of manifestations of sickness.

It's that whole holistic what else is happening. Because that has a big impact, you know, the family situation, the home situation, all of that, you know, the travel, the access. You know and a lot of people don't want to say, you know, "oh, I don't have the petrol, I can't get there." (Elsa)

Yet, at the same time, GPs and practice nurses argue that the scarcity of time within the general practice has resulted in them increasingly providing care only within the general practice: "It's very difficult for us to do home visits anymore. The time pressure is huge." (James).

8.4.2 Home as separated from PHC

There are a number of processes in health and social systems which separate people's homes from PHC that were visible in this study: people need to leave their home to 'go to the doctor'; people leave the 'doctor' to go home; and people are 'discharged home' from institutional care (particularly hospitals) with letters related to this discharge being sent to their general practice. Practitioners spoke about a number of aspects of this separation.

Homes are separated geographically from the site of PHC. This physical separation contributes to GPs not doing home visits; it also can lead to people in homes having to surmount obstacles to get out of their house to go to sites of PHC. Difficulties accessing transportation featured high on this list of obstacles. However, there were other obstacles related to illness and ageing. For example, Martha at the iwi provider of Site One is asked in one story, "will you come and see my mother, she has a broken arm and I can't get her out of the house, she needs this, and she needs that" (Martha).

The physical separation can also negatively impact upon treatment plans of practitioners. Once a person has left the site of PHC and gone home the transfer of knowledge about the treatment is seen to be complete by the practitioner. Martha relays a common scenario: "nobody really explained to him that actually the tablets are three-times a day. And if they had, he'd forgotten by the time he'd got home. And his eyesight's so poor he can't read the label on the medicine bottle" (Martha).

A final separation between home and PHC is an ideological separation where people do not see the PHC provider, particularly a general practice, in a favourable light: "the barrier of the medical centre itself, it's an institution" (Kevin). This leads to a reluctance to seek care from that provider. Practitioners in both the iwi providers spoke of the importance of their work for these people. Kevin spoke about setting up clinics in places where people wanted to go, where they saw they already had a relationship to the place: "it's going to a place which is close to a person's home environment, you know, more of a community environment" (Kevin). Similarly, Diane (with the iwi provider at Site Two) explained how she sees the work of the iwi provider in relation to the home: "who doesn't come to the GP? And who doesn't come to their appointments? And who's getting sicker at home with no phone? That's the work we pick up, and that's like the real work" (Diane).

In Aotearoa /New Zealand our PHC policy has consistently named the importance of care being close to people's homes, including in the PHC Strategy: "Some people are

physically unable to get to first-contact services. Primary Health Organisations will need to go actively out to people who cannot or do not come to them. They need to be open to providing services in a range of different settings, for example in people's homes, workplaces, in schools, or on marae" (King, 2001, p.16), a view reiterated in subsequent policies including *Better Sooner More Convenient PHC* and *Care Closer to Home* (see Chapter Six – Landscapes).

8.4.3 Home as a site of PHC service provision

This study has shown that PHC is provided in the home by community-based practitioners who work for social services, iwi providers, and practitioners employed directly by the PHO. Communication between these practitioners who provide PHC in the home, and those practitioners working within general practices then becomes crucial. Many of the features of interprofessional collaborative practice identified in this study have centred upon these relationships between those outside of the general practice with those practitioners inside the general practice. Several of the narrators described the kinds of skills and knowledge that the practitioners outside of the general practice required to be able to work directly in people's homes.

For example, Kevin in the iwi provider at Site One believes that other members of his team are better placed at doing home visits because they are better equipped than he is to deal with the social problems (he calls "the real issues") that are common with the people who use their services: "poverty in the household, violence might be going on, social strife, the kids are playing up" (Kevin). It is not until his colleagues are working with these issues that his work as a clinician, he argues, on clinical needs like diabetes can make a difference.

Claire at Site Two similarly names the complexities of the people with LTC that services like the Wellbeing Support Team need to engage with when they go into people's homes: "difficult diabetics, difficult people that have got difficult social circumstances and not getting access to everything that they need" (Claire). To be able to work with these people requires certain skills. Claire names some of these as she describes Jane and Leah from the Wellbeing Support Team. When describing Jane she notes that Jane is able to get in the door of people's home when other workers cannot: "she has a good rapport, particularly amongst the Māori, and Island, and Pacific Island people"; "She can fit in anywhere"; "she doesn't care if she goes in the house and there's dead dogs in the corner" (Claire). When

describing Leah she notes Leah has, “and excellent educational background, you know, and she’s also a good guiding force for those other two [Jane and Robyn]” (Claire).

8.5 Conclusions

The 2001 PHC Strategy established a vision of how to improve PHC service provision in Aotearoa /New Zealand. The place of interprofessional collaborative practice across organisations was key to this vision. This vision has been reinforced through other policy initiatives since that time and is supported in the PHC literature. In this chapter I have focused on a consideration of where PHC takes place, what is the nature of this care in those places, and who is involved in providing this care. I argue it is only through clarity on these aspects that we will be able to realise this vision of improved PHC through increased ICP.

I have shown in this chapter that PHC occurs in a range of places across communities and is provided by a variety of professionals located in different types of organisations. In spite of this, the dominant PHC discourse continues to locate PHC within the general practice where the main providers of care are GPs and practice nurses. From one perspective, there is much sense in this, given that GPs are the part of the medical workforce that are trained to work in PHC. However, their centrality and the dominance of the general practice as a site of PHC shores up a biomedical discourse of PHC. As Lapun et al. (2016) note:

> Despite the benefits of the biomedical model, it can lead to a neglect of the place and space of individuals and the impact of geography on the meanings of health. PHC maintains a different philosophy of care and requires a reconceptualization of health and how care is delivered. (p.136).

This raises an important question on whether the vision of the PHC Strategy can ever be implemented in this country. This concern is a central feature of the following chapter which examines the discourses of ICP and RP that analysis has identified.

Chapter 9 – A synthesis and discussion of discourses of ICP and RP in PHC

9.1 Introduction

In the previous two chapters I have explored ICP and RP in PHC through a narrative analysis (Chapter 7) and examined the significance of space and place to ICP (Chapter 8). In this chapter I draw on these analyses to discuss the discourses which are at play with regard to ICP and RP within PHC in Aotearoa/New Zealand. Three discourses of interprofessional collaborative practice in PHC have been identified and three discourses of RP.

In the first part of this chapter a full description of these discourses is provided, identifying links to the analyses of the previous chapters. Key features of these discourses are then elaborated paying attention to what knowledge is valued in each discourse and how power is manifested. This elaboration of the discourses provides a context for the discussion which follows and explores the complex interplay between the discourses.

The actions of GPs, practice nurses, and other members of the health workforce at the two study sites demonstrate the complexity of the interplay between these discourses in PHC. Tensions between these discourses are discussed, with the dominance of GP-centred ICP discourse being evident. Also discussed are the ways that some discourses can co-exist and reinforce manifestations of power, with an important example being GP-centred ICP and Business-centred ICP.

A further important topic in the discussion explores the connections between the discourses of RP and ICP. Though practitioners were clear about the potential connections between RP and ICP, the ways that power is manifested in the discourses signals much concern on the potential for these connections to result in better ICP. Of particular concern are the ways that the RP associated with accreditation and registration processes of professional bodies remains strangely adrift from narratives of ICP.

As I examine the discourses which constitute the ICP actions of practitioners, I have maintained a sociology of knowledge approach and kept a focus on the social actors themselves, maintaining the stance that "social actors are not puppets on the strings of discourse, but (inter) active and creative agents engaged in social power plays and struggles for interpretation" (Keller, 2005, para. 7).

9.2 The three discourses of ICP

The first of the discourses of ICP places the GP and the general practice at the centre of the practices of interprofessional collaboration and is thus named *general practitioner-centred ICP* (*GP-centred ICP)*. In the second discourse, ICP is organised around the person seeking care and is thus named *person-centred ICP*. The third discourse is situated within the private health care context of PHC within Aotearoa. In this context, the economics of private enterprise hold sway. The person seeking care becomes constituted as a consumer of services and is charged a fee for services or products that are provided by practitioners in general practices and pharmacies. Health care becomes a series of consumer transactions with providers operating as profit-making businesses, so this discourse is named *business-centred ICP*.

9.2.1 GP-centred ICP

The ICP constituted by this discourse centres upon the GP. ICP action is initiated by the GP in response to their analysis of patients' needs through the application of biomedicine. The general practice provides the organisational structural context for the perpetuation of this discourse. Though this discourse of ICP is centred upon the GP, it is important to note the discourse constitutes the actions of other social actors in PHC. The narrative analysis in Chapter Seven and the analysis of the place of PHC in Chapter Eight provide many examples of this. For example, the kaiāwhina in Narrative Three of Chapter Seven, identified the people that the Wellbeing Support Team works with as belonging to the general practice: "It's their patient. They've given us the respect to refer their patient to us in some way or form" (Jane). The collaboration is thus at the behest of the GP.

GP-centred ICP is also visible in the ways that GPs and practice nurses work with each other within the general practice. The10-minute appointments are an important mechanism of this discourse which constitutes the nature of the ICP between GPs and practices nurses. The GPs and practice nurses identified that a consequence of the practice nurses spending more time with patients was that the practice nurses had a fuller picture of the patient: "Our nurses often have the in-depth knowledge of social background and understanding of -- they've built the relationship as such, they're the one that that person trusts" (Lisa). In spite of this more in-depth knowledge of the patient, this discourse maintains the locus of power with the GP. The practice nurse at the IFHC of Site One articulates a range of ways this is maintained:

> *We're not going to make a diagnosis, we might make one in our head, but we're not going to make a diagnosis and tell the patient, and treatment plans are up to the doctor, drug choice is up to the doctor.* (Josie)

The GP in the iwi provider of Narrative Two in Chapter Seven provides a further glimpse into the manifestation of GP-centred ICP as he contrasts the way he operates in the iwi provider compared to his previous experience within a general practice. He describes the general practice environment as "typically hierarchical, GP at the top, nurse underneath, and their practices [the nurses] in a very subordinate role" (Kevin). Though Kevin and others in this study have noted this hierarchy is changing, they describe this change as slow. The powerful place of the GP in establishing ICP remains.

When Kevin describes his role as a GP in the iwi provider it appears the GP-centred ICP discourse is much less influential. He explains he is only there two and a half days a week and the nurses "take on board a lot more responsibility" than in a typical general practice.

> *I'm peripherally involved most of the time, so they're operating on their standing orders a lot, which I help to supervise the standing orders, so they diagnose and treat, and then what they might do is they might discuss the cases with me if it's a bit complicated or outside of their area of expertise.* (Kevin)

Within the Medical Centre of Site One, Denise the social worker has no idea that this alternate ICP discourse is already operating within her community. At the Medical Centre, Denise's work with families is primarily initiated by the GP, demonstrating the ongoing ways that GP-centred ICP continue to constitute care. This frustrates Denise who reflects, "I think that sometimes they don't even need to see the doctor", even though that is who they make an appointment to see. The centrality of the GP is constituted through actions of the patient, the receptionist, the doctor, and indeed the context of the general practice.

Denise's frustration signals the power of the discourse of GP-centred ICP which even constitutes the actions of people seeking care. Referring back to the work of Kögler (1996; 1997a; 1997b), the background interpretive schemes of patients themselves are influenced by this GP-centred ICP discourse. Patients are clear they need "to see the doctor" (Denise) and this entails making an appointment at a general practice, the domain of the GP. Denise envisions an alternate future where people/patients can seek care from a PHC organisation made up of a range of practitioners. In this hypothetical situation she envisions people would

receive whatever care was needed from whatever practitioner was best suited to meeting those care needs.

Denise's vision closely aligns with the vision of the PHC Strategy 2001 where PHC did not need to be centred upon the general practice and the role of the GP. There are synergies between the GP-centred ICP discourse in this analysis and notions of primary medical care (PMC) discussed by other authors (McKenna, 2012; Starfield, 1992). As succinctly described by McKenna (2012), PMC "is directed towards a conventional biomedical orientation (cure, episodic care, passive patient reception, and physician dominance)" (p.3). The power of the GP-centred ICP discourse is evident in the multiple actions of all, including the GP. In Chapter Seven a resounding message from all was that the GP was time-poor. An alternative way of organising clear seems impossible to contemplate given the constituting power of GP-centred ICP.

9.2.2 Person-centred ICP

The second discourse is primarily situated outside of the realm of the general practice where the GP holds dominion. Person-centred ICP is particularly visible in the social actions of the practitioners who were located within the iwi providers and the Wellbeing Support Team. Indeed, in this study the GP is commonly quite distant from this care provision. In the person-centred ICP discourse, the needs of the person seeking care are at the centre of ICP, thus I have named this discourse *person-centred ICP*.

In the contexts where person-centred ICP is prevalent, a person needing healthcare comes into contact with health care practitioners in a variety of ways. In the narrative analysis some examples included these: people going to a pharmacist; the nurse practitioner finding people to give flu jabs; and the Wellbeing Support Team receiving a referral from a general practice. The healthcare practitioner works with this person needing healthcare and helps them make sense of their own health needs. Then, the practitioner utilises their established relationships with other practitioners and other providers in the health and social services sector to weave care around the person. Processes of navigation and activation are utilised where the person within the context of their family, whanau and community become crucial to care.

The influences of the person-centred ICP discourse enable practitioners to be more able to recognise and engage with the social determinants of health. This was especially visible in the iwi provider of Site One, where the GP Kevin notes, "So we are seeing high

needs people, they have complex problems - often social problems - best not dealt with by a doctor, but best dealt with by a team of people to work together and try and solve problems" (Kevin). He goes on to explain a need to shift out of the medical paradigm when engaging in this form of ICP:

> *If I'm seeing someone with diabetes, I could talk 'til I'm blue in the face about taking a pill. But the real issue is the poverty in the household. Violence might be going on, social strife, the kids are playing up, whatever. So we have to work together as a team, as well as bringing in other people to try and work with that whanau before I can even address the diabetes.* (Kevin)

The influences of the person-centred ICP discourse can, thus, lead an organisation down a path of employing professionals who are not GPs or practice nurses. For example, Kevin explains that the iwi provider where he works employs people that a "conventional general practice doesn't have" (Kevin) such as nurse practitioners, community support workers, health navigators. This involvement of practitioners other than GPs and practice nurses was also visible in the gout project of Narrative One, where the roles of the pharmacist and the arthritis educator were key to the ICP.

Although the above examples of manifestations of the person-centred ICP are outside the general practice, there were instances where the person-centred ICP discourse was visible within the general practice. These glimpses of this discourse operating within the general practice were associated with GPs and practice nurses recognising that the care people required was beyond the care that they alone were able to provide, particularly as a consequence of time scarcity within the general practice. For example, the Medical Centre of Site One had employed a social worker for some time, recognising the various needs for patient support that went beyond the skills of nurses and GPs.

As the nurse clinical leader, Tina, described some of the different ways the social worker and the clinical team worked together she recounted a story about a baby who was overdue for vaccinations. Tina explains that she was about to request that one of the practice nurses contact the family to bring the child in, when she saw that the social worker had documented "a myriad of social issues going on at the moment" (Tina). This prompted Tina to step back from the recall for vaccinations at the moment knowing the family was busy working through these issues with the social worker.

9.2.3 Business-centred ICP

The third discourse identified in this analysis was visible in the business imperative of general practice owners and pharmacy owners. Considerations of business survival and profit-making have led me to name this discourse *Business-centred ICP*. The most pervasive effect of this discourse on ICP in PHC is the construction of the seemingly unchangeable 10-minute appointment. Although the length of the appointment time slot with a GP in Aotearoa/New Zealand is often identified as 15 minutes (Health Navigator New Zealand, 05 June, 2021), in this study it was almost always named as 10 minutes. GPs claim that the scarcity of time, as a result of the pressures of these 10-minute appointments, interferes with their ability to prioritise ICP.

A significant contributor to the establishment (and immutability) of the 10-minute appointment is the business model of the general practice and the expected salary of the GP. Delivering care becomes re-defined as reaching a salary target. General practices estimate how many patients they need to enrol in their service based on what income can be generated from the combination of fees they charge patients and the Government subsidies paid. This anticipated income of the general practice is a major factor in the establishment of the number of available appointment time slots with GPs that the general practice must provide. The focus of the GP shifts away from care of the patient towards achievement of system efficiency.

One consequence of restrictions on the GP's time is they now rarely leave the general practice to do home visits – a practice that was once common in Aotearoa/New Zealand. Additionally, after hours care no longer occurs in general practices but has been shifted to private after-hours services commonly named accident and medical clinics or urgent care clinics. Increasingly, it has been noted that increasing numbers of people do not enrol with general practices for a variety of reasons (e.g. unpaid bills with a general practice) and instead seek care from these private accident and medical clinics.

The business-centred ICP discourse constitutes care as happening within the business of the general practice where people are enrolled as income-generating units. The practice manager of the Medical Centre at Site One identified the "restraints and restrictions" that this consideration places on the type of care the general practice can provide and who provides that care. The GP is the primary income-generator for the general practice and is the most expensive staff member. Wherever possible, practice nurses, who are a cheaper resource

need to do most of the work. Tina, the practice nurse of the Medical Centre at Site One relayed the way this commonly plays out. She described working with a doctor who strictly enforced his 10-minute appointments: “he had his appointments, and they would literally come out of the door and they would come into my room to get the rest of the consultation that they didn’t get with him” (Tina).

The business-centred ICP is also visible in the PHC of pharmacies. John, the pharmacist at Site One in Narrative One explains that this commonly leads to pharmacies competing with each other for customers. One consequence of this is that pharmacists strive to develop relationships with specific GPs in local general practices to channel customers to the pharmacy. There a range of mechanisms that assist with this including the pharmacist being seen to be helpful to the GP and to the general practice. A consequence is that GPs will recommend/advise patients to purchase materials they need for their health care from the local pharmacist and pharmacy.

Table 20

Key aspects of the discourses of interprofessional collaborative practice

	GP-centred ICP	**Person-centred ICP**	**Business-centred ICP discourse**
Brief description	ICP is centred upon the GP's determination of the patient's need through diagnosis. Following diagnosis, treatment by the GP may involve other health care practitioners via ICP.	ICP is centred upon identifying and responding to wide considerations of the needs of people/patients. The views of people/patients are placed at the centre of ICP action. ICP can be initiated by a range of practitioners both in and outside the general practice.	ICP is centred upon the provision of efficient and effective care to patients who are conceptualised as consumers. The discourse requires the patient/consumer to identify one problem to be met within a ten-minute appointment. ICP is one aspect of an efficient service response to that problem; ICP involves delegating tasks or making referrals.
ICP thus focuses upon	Within the general practice: ICP primarily involves GPs and practice nurses. Inter-organisationally: ICP framed by referrals from the GP to other health care providers (e.g. laboratory services, medical specialists). Practitioners from other providers communicate information back to the GP (e.g. via hospital discharge letters).	ICP is founded upon building and maintaining relationships with diverse practitioners across a range of health and social services providers. These relationships enable multiple responses to a range of social and health care needs (visible in the work of the Wellbeing Support Team and both of the iwi providers).	Service provision in response to consumer demand. Cost-efficiency necessitates reduction of the amount of time that the most expensive practitioner is involved in service provision. Wherever possible other practitioners who are low-cost, or no-cost are involved in care. Development of ICP that enables income-generating activities (e.g activity of practice nurses that can be reimbursed).
What knowledge is valued	Biomedicine dominates. The discourse determines one health concern is addressed per visit, thus, the most severe health condition is focused upon. Preventive care takes a back seat.	A bio-psycho-social approach to health. The person's needs are seen within the context of the social determinants of health. A recognition of the importance of preventive health and the place of health education. Cultural knowledge is valued.	A complex interplay of the importance of evidence-based biomedicine (as the most efficient service response to sickness and disease) and business efficiency.

	GP-centred ICP	Person-centred ICP	Business-centred ICP discourse
How is power manifested	A hierarchy of power is evident: GP → practice nurse → community-based nurse → kaiāwhina → patient. Careful support and navigation through the power hierarchy is required. ICP is identified & controlled by the GP from within the general practice. The GP is the gate-keeper to other services. The centrality of the GP is maintained by numerous health systems: policy, funding, laboratory testing/results, and hospital discharge letters	An inverse hierarchy of power compared to GP-centred ICP. Practitioners endeavour to share power with people/patients so as to enable collaborative practice with them. Practitioners put efforts into breaching professional silos to ensure a focus on the care of the person/patient. Practitioners outside of general practice struggle to get their work documented within the general practice.	RNCGP continues to stand against the state and maintain GPs right to charge fees. Patients belong to the general practices they are enrolled with – the income-generating power of each enrolee is protected. GPs exert their power to establish 10-minute appointment slots as a profit-maximising mechanism to contain time wastage. The discourse necessitates patients/consumers identify one 'problem' that the service provider can respond to.

9.3 The three discourses of RP

Three discourses of RP were identified. The first of these is shaped by the expectations of the professional bodies which govern health professionals (for example, the Medical Council of New Zealand and the Nursing Council of New Zealand). These bodies operate under the authority of the Health Practitioners Competence Assurance Act 2003. They establish expectations of standards of practice as a part of their accreditation and registration processes and measure their members' conduct against these against competency standards. RP expectations are one component of these standards. This discourse is, thus, named *competency-based RP*. The second discourse is more closely associated with the professional's caring relationship with patients and is called *individual-care-giving RP*. The third discourse is situated within the organisational context of the practitioners' work. This discourse, therefore, is much more interwoven with the work of other practitioners within the organisation and is named *team-based RP*.

9.3.1 Competency-based RP

The first discourse identified is centred upon the expectations of professional bodies that govern the accreditation and registration processes which shape the RP of professionals. These professional bodies are accorded authority as regulating bodies for their profession through the Health Practitioners Competence Assurance Act 2004. The professional bodies establish standards of practice, commonly called competencies, for their members. One component of these competencies that is common across the professional bodies is the competency of RP.

Having established the standards of practice, the professional bodies put in place mechanisms for their members to demonstrate their level of competence against these standards. For example, the nurses commonly referred to the PDRP expectations of the Nursing Council. Each professional body lays out a series of tasks their members must carry out at regular intervals and RP is woven into these tasks. GPs for example are required to participate in 10 hours of peer review group activity annually. GPs are also required to undertake audits of their practice and carry out a certain number of PDSA[33] cycles where they implement changes to treatment plans. I have named this discourse *competency-based RP*.

[33] The Plan, Do, Study, Act (PDSA) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action-oriented learning.

9.3.2 Individual-care-giving RP

The second RP discourse identified was focused on practical aspects of individual practitioners providing better care for people/patients and I have thus named this the *individual-care-giving RP.* This discourse particularly shaped the individual practices of reflection. Martha described a focus upon maintaining your knowledge base so as to "engender trust with your patients" (Martha). Commonly practitioners described situations where their practice paused (for example in a hurried lunch break or at the end of their day) where they thought back upon particular actions they had just taken, or not taken.

The podiatrist of Site One described driving home and thinking back on something that happened during her day and saying to herself, "right! I need to do this tomorrow" or "I need to investigate that" or "I need to follow up with talking to…" (Adele). This kind of activity was understood (and supported) by non-clinical people as much as clinical people, that is, it was not tied to profession-specific practices. For example, Mary, the non-clinical practice manager of the Medical Centre at Site One described the importance of "just taking a step back from the day-to-day stuff, to consider whether there's a different way of doing it, or a better way of doing it".

In other instances the presence of a wise colleague, mentor, or supervisor assisted with individual-care-giving RP. Kevin, the GP in the iwi provider of Site One describes being "able to work through things, and deal with things" in his external supervision relationship that led to improvements in his practice. Similarly, both Jane and Robyn in the Wellbeing Support Team of Narrative Three describe important conversations they have with Leah which enable them to re-focus their actions with the people/patients they're working with.

9.3.3 Team-based RP

The third discourse was situated more clearly within the organisational and work context of practitioners. An important aspect of this RP discourse is its connection to enabling the wider team or the organisation to operate more effectively. This discourse influenced practitioners to focus on improvement in the collaborative practices amongst their colleagues. In one example the practice manager of the Medical Centre in Site One commonly used language of quality improvement of the practice team within the general practice. However, other instances of this discourse could be seen in wider notions of team, that is, working in a team-based way with practitioners from other providers. This was

visible in the work of the pharmacist in Narrative One and also in the work of the Wellbeing Support Team. I have thus named this discourse *team-based RP.*

Working alongside others in caring and trusting relationships is highly valued in manifestations of this discourse. The podiatrist at Site One, Adele, describes her relationships with her colleagues at the IFHC:

> *We take care of each other. When you're in isolation you're more likely to burn yourself out and be unaware of it. Where, here, we can tell when each other's stressed, we're having a bad day. We make each other cups of tea, or we talk about it* [the bad day]*, or like, "is there anything I can do to help?"*

Through these kinds of relationships, Adele explains, they are able to develop collaborating practices where they involve each other in reflections upon their work. At the IFHC, more than anywhere else, Adele notes, she is much more able to pause and seek support from the physiotherapist or the GP. To approach them and be prepared to say: "I'm not sure about this, what do you think?" (Adele). For Adele this means she feels safer in her practice. Lisa, the GP in the practice tells similar stories about the ways she reflects and collaborates with Adele.

At Site Two multiple manifestations of team-based RP were visible in the ways that the Wellbeing Support Team spoke about how they worked with each other. There were also instances where others spoke about what they observed in the ways that the Wellbeing Support Team worked which indicated the presence of this team-based RP. For example, Elsa identifies the ways that Leah, Jane and Robyn work with each other as being quite different from the teams in the Pacific and iwi providers. She describes them adopting a clear stance of "we don't know much, but we're keen to learn" which underpins their engagement with her as a clinical nurse specialist. Then, she notes, they discuss this learning with each other and establish a rationale for action (with Elsa's support) and confidently engage with GPs to present plans of action to improve care.

Table 21

Key aspects of the discourses of RP

	Competency-based RP	**Individual-care-giving RP**	**Team-based RP**
Brief description	Participating in activities established by professional bodies and documenting these in required ways for the purposes of competency assessment and/or recertification (e.g. RNZCGP requiring GPs to participate in 10 hours peer review group activities)	Returning to examples of your own practice to consider how care could have been improved or done in a different way.	Meeting and talking with others who share care with patients to consider individual and collective roles so as to improve care
RP thus focuses upon	Activities are outlined in a range of documents (e.g. competency assessment guides/instructions) and informed by standards of practice established by the professional body (e.g. scopes of practice; practice standards) The intent is to encourage the practitioner to conceptualise possible links between theory/evidence and practice Commonly incorporates activity focused upon: • content of training events, workshops and conferences • structured reflections on practice events	Commonly an individually motivated meta-cognitive activity happening close to the time of significant practice events May be an activity occurring within a supervision or mentoring relationship	Considering the systems and processes that shape people's experiences (patients and colleagues) Improving the experiences of the people using services Building better collaborative relationships
What knowledge is valued	Profession-specific knowledge (e.g. Medical Council and RNZCGP value evidence-based practice).	Practice wisdom of valued colleagues/mentors/supervisors Notions of best practice Implementation of guidelines	Organisational change and quality improvement Team working
How is power manifested	Professional bodies are accorded authority as regulating bodies for their profession through the Health Practitioners Competence Assurance Act 2004. Practitioners must complete the activities and document them in the required way to maintain their right to practice	Individual personal professional power Can be strongly influence by cultural and familial connections	Authority of the team who are within the organisation is mandated by the organisational infrastructure Authority of the team across organisations reinforced by personal professional power

9.4 Synthesis of discourse analysis of interprofessional collaborative practice and RP

9.4.1 GP-centred ICP and business-centred ICP

GP-centred ICP and business-centred ICP are mutually reinforcing discourses within the general practice. The constituting of care through the mechanism of time is one feature in common across both discourses. In both these discourses, the 10-minute appointment shores up the place of the GP. Both GPs and practice nurses were especially clear that scarcity of time required them to work in particular ways with each other: GPs identified the practice nurse as triaging their patients; Practice nurses identified the ways they pick up the real work that needs to be done with patients after they've had their 10-minute appointment with the GP.

Both the GP-centred discourse and the business-centred discourse generate a powerful resistance to conceiving of any alternative to these 10-minute appointment time slots. All the people interviewed in this study accepted these 10-minute time slots as an immutable reality. Within this accepted reality, both the discourse of GP-centred ICP and business-centred ICP perpetuate the need (and capacity) for GPs to set the agenda of what collaboration is, and who will be collaborated with. Everyone who participated in this study recognises the imperative of this discourse and associates the scarcity of time for its perpetuation.

Business-centred ICP also drives activity of the pharmacist in Narrative One. John describes the contributions of ICP to avoiding time-wasting, at times referring to this as preventing fires, rather than having to put out fires further down the track. For John this drives ICP with general practices naming this activity as "a financial plus" (John) for the pharmacy.

Business-centred ICP is located within a broader neo-liberal discourse of GPs in Aotearoa/New Zealand retaining the right to charge fees and the right to run their general practices as profit-making businesses. A number of authors (Crampton & Starfield, 2004; Gauld et al., 2019; 2017) have written about the ways that this has stood in the way of Aotearoa/New Zealand being able to effectively implement the PHC Strategy 2001. An important finding from this research, however, is the strong synergies between business-centre ICP and GP-centred ICP. Without addressing the ways that funding systems reinforce business-centred ICP, it will never be possible to address the ongoing influence of GP-

centred ICP. Recognising the long history of the intersections between these discourses is an important beginning. McKenna (2012) argues that the inter-relationships between the dominance and success of biomedicine at the turn of the 20th Century can be partially attributed to a convergence of worldviews between biomedical professionals and capitalists.

> Imagine a world where each group's expertise is held in regard, offered, and shared as the need arises. Imagine a time when the patient can determine which kinds of practitioners he or she needs or wants, and then imagine a system that makes those professionals available. (Carroll-Johnson, 2001, p.619)

9.4.2 GP-centred ICP and person-centred ICP

The significance of the general practice to PHC in Aotearoa/New Zealand and the associated dominance of the discourse of GP-centred ICP has been established. In spite of this dominance, analysis over Chapters Seven and Eight indicates the presence of an alternative ICP discourse, the person-centred ICP. As noted in the description of this discourse earlier in this chapter, the person-centred ICP is particularly visible in providers outside of the general practice like the pharmacy, iwi providers and in the community-based activity of the Wellbeing Support Team.

In the previous section it was noted that the discourses of GP-centred ICP and business-centred ICP collectively work to minimise the time practitioners (particularly GPs) spend with patients. In contrast, the person-centred ICP influences practitioners and providers to strive to find time to connect with people and establish the breadth of their needs and the current strengths people have to be built upon to improve their wellbeing. Practitioners outside of the general practice recognise an irony in this situation. They find themselves commonly working with people who have become disconnected from the general practice for a variety of reasons: they may not be able to afford the fees of the general practice, they may have unpaid bills at the general practice, or they find the general practice inaccessible either physically or culturally. The nurse manager of the iwi provider at Site Two describes this context:

> *Sort of the sick person comes in* [to the health system]*, you know, they sort of, the DHB does the first part, you know. The PHOs pick up the next part. And who doesn't come to the GP? And who doesn't come to their appointments? And who's getting sicker at home with no phone? That's the work we pick up, and that's the real work.* (Dianne)

To engage with these people requires a significant investment of time, effort and resources. General practices seldom initiate contact with absent patients who are not seeking

care. Instead, it is the practitioners outside the general practice that strive to make connections with these people. Many instances of these efforts were relayed by Martha, the nurse practitioner at Site One.

This work carried out by practitioners like those in the iwi providers and the Wellbeing Support Team sits in stark contrast to the ways that general practices operate. Provision of care within the general practice relies for the most part on patients identifying their health needs and initiating contact with the general practice. Typically, in this study people phone a general practice and speak to a receptionist to make an appointment with a doctor. Literature often refers to this as patient-initiated episodic care (McKenna, 2012). In this context GP-centred ICP continues to dominate.

The presence within the general practice of a person-centred discourse in ICP can, however, still be discerned. In both study sites, the PHO initiated actions in which a person-centred ICP was more visible. In Site One, the PHO drove the gout project. In Site Two the PHO established the Wellbeing Support Team. In both these instances, although the work of people outside of the general practice was key, there was important activity within the general practice to support the person-centred ICP that was a part of the PHO action. One of the general practices that was an active player in the gout project was the IFHC.

When the pharmacist in Narrative One considered his ICP with general practices close to his pharmacy he noted that the doctors at the IFHC in Site One operated in a different way to the doctors at the Medical Centre:

> *They seem to be more engaged with the patient in some respects, rather than-- to them it's not-- it doesn't appear to be a money-making venture, if I could be so crude as to say that. And, I think that-- so they're quite-- yeah, they're, you know, very much into the care of their patients.* (John)

Certainly, the IFHC had established themselves with a wider pool of professionals than just a GP and a practice nurse with a podiatrist, a physiotherapist and a social worker all playing important parts in their model of care. The relationships between these practitioners appeared to lend more strength to the place of the person-centred ICP discourse. Nevertheless, the hierarchy of power with the GP at the top was still evident from analysis of the texts and the dominance of the GP in shaping the practices of the general practice remained. This dominance was acknowledged by the GP at the IFHC who identified the ongoing work required by her to keep addressing this dominance. In Chapter Seven several ways this work occurred were outlined including the efforts put into responding to wider

community organisations around the IFHC, and at a more personal level her responsiveness to the challenges of her allied health professional husband.

Kevin, at the iwi provider, similarly named the importance of the work required by each individual GP to address their own power in order to create a context for ICP:

> *As a doctor, to work collaboratively, you have to give up-- you have to acknowledge your own power and you have to manage your power and you have to work with your power, so umm not having power over* [others].

9.4.3 Engineering circumstances to initiate interaction

There are a number of episodes in this study where practitioners outside of the general practice describe the ways they engineer circumstances to initiate interactions with practitioners within the general practice who have more power. Some different motivations are named as underpinning these actions. Sometimes these interactions are used to build and consolidate collaborative practice relationships so that they can provide better care for their patients. For example, the nurse practitioner in Narrative Two, Martha, used the strategy of visiting all the pharmacists in her district with a piece of paper that had her photo, contact details and signature. Martha identified this as a pragmatic way to build ICP relationships with the pharmacists, but also a means to educate the pharmacists about the role of a nurse practitioner role and their ability to prescribe. Moreover, she wanted to pre-empt situations where pharmacists might not dispense needed medication for people because they cannot find her on the list of people authorised to prescribe issued by the Medical Council.

These engineered conversations can have a component of an offer of a service. For example, Martha described the ways she visits general practices and offers to help with flu jabs of difficult-to-reach people. Each of these visits builds her understanding of the general practice, who works there, and which clients connect with which general practice. It also demonstrates to the general practice who she is and how she can work from outside the general practice to still provide collaborative care. Martha explains that these efforts as "linking and liaising" noting that if she didn't do put this time into these activities "nobody would talk to us" (Martha).

All three of the pharmacists also described engineering circumstances to build and maintain their collaborative relationships with practitioners inside the general practices. A common strategy is to make regular visits to the general practices under the guise of checking the supplies in the medicines' cupboards of the general practices which are

routinely maintained by pharmacists. One pharmacist, Christine, explained how checking the cupboards is a required task, but she does this with the primary purpose of engineering face-to-face conversations with the GPs: "we need to know the face of each other, we need to be friends, and we need to re-iterate that we are in the same team, or we are not separate" (Christine). In some instances these engineered visits are to resolve problems, for example "we have an issue with the script or if we think a customer's not taking the medication right" (Christine). In these cases, Christine goes to the general practice and pretends she is there to check the medicine cupboard stores:

> *If I see them free I just catch them quickly, yeah, and then I can actually get to talk to* [the practice nurse] *who knows pretty much what's going on around here. Yeah, or sometimes, if I'm lucky, I can get hold of the doctor.*

The manifestation of power in GP-centred ICP is evident in Christine's strategising.

In Site Two the practitioners in the Wellbeing Team described the ways they engineer to make contact with doctors and practice nurses within general practices. A culmination of this relationship-building over time meant they invited by some general practices to document their work with people/patients in the patients' notes within the computers of some general practices. Having this permission created further opportunities for the Wellbeing Support Team members to be able to engineer a visit to the general practice under the guise of writing notes in the computer. When in fact there were important ICP conversations required with either the practice nurse or the doctor.

These examples demonstrate the most common pattern that it is the practitioners outside of the general practice with less power who engineer circumstances to create possibilities for ICP. However, of note were instances relayed by the GP of the IFHC where she signalled that ICP between the IFHC and community providers would not happen unless she made the time to network and initiate contact with them.

9.4.4 The interplay between discourses of RP and ICP

The different discourses of RP did not clearly map onto the different discourses of ICP. Nevertheless, one clear pattern visible from analysis is a separation between discourse of competency-based RP from the day-to-day reality of reflecting on care represented by individual-care-giving RP. Practitioners recognised that the power of competency-based RP required them to comply with the expectations of their professional body. This compliance, however, was named as distant from the care they provided in their practice. For example,

the nurse practitioner of the iwi provider at Site One described having to "justify who I am to the Nursing Council" in her reflections in her PDRP portfolio, whereas, her important day-to-day reflections on her work with patients is more focused on enabling her to engender trust with those patients.

This separation between the discourses of competency-based RP and individual care-giving RP is also visible in comments made by Elsa, the clinical nurse specialist at Site Two: "I find more value in the ones [reflections] that I'm doing with my colleagues", she notes, explaining these reflections with her colleagues are "probably more concrete and more specific to what I'm doing, and actually looking at how it impacts on my practice" (Elsa). In this way Elsa is valuing the individual-care-giving RP above competency-based RP.

In these examples there appear strong connections between the RP discourse *individual-care-giving RP* and the interprofessional collaborative practice discourse *person-centred ICP*. In both sets of discourses it is not the outside authority of 'other' (their professional body in terms of competency-based RP; the power of the GP in terms of GP-centred ICP) but rather their valued relationships with their colleagues who stand alongside them offering care.

Within the context of the general practice, the competency-based RP discourse seemed to be more dominant than the other discourses of RP. When all three GPs began speaking about RP and its connections to their work, they spoke first about their professional body expectations of PDSA cycles, the requirements to carry out clinical audits and the requirements to participate in peer review groups. Nevertheless, the presence of the other RP discourses was still evident within the general practices, particularly in the text related to the Medical Centre at Site One.

Mary, the non-clinical practice manager of the Medical Centre at Site One spoke a number of times about common-sense problem solving of relationships amongst providers and practitioners is necessary for "seamless care for the patient" (Mary). In these examples, the influences of team-based RP upon the discourse of person-centred ICP were visible. Yet, at the same time the presence of the business-centred ICP is visible in the ways that Mary sets limits on what work the Medical Centre is able to do to respond to people's needs: "we would like to be all things to all people" Mary notes at one stage, but explains the business model prevents this.

9.4.5 Care co-ordination and collaboration

The PHC Strategy established PHOs to coordinate care across organisational systems. One aspect of coordination is the importance of coordination between primary and secondary care, particularly for those people living with LTCs: "the best care of patients with chronic conditions such as diabetes, respiratory and/or cardiac disease may occur in PHC settings, but with significant input and support from secondary services" (King, 2001, p.19). General practices have remained the PHOs main mechanism to carry out this coordination. General practices are also the site of GP-centred ICP which shape key communication pathways between primary care and secondary care in terms of hospital discharge letters, and results of laboratory testing.

This discourse analysis, however, has identified that significant care of people with LTCs occurs outside of the general practice and outside the interests of the GP-centred ICP. That is, actions constituted by the person-centred ICP discourse commonly occur outside of the general practice, and actors find it difficult to connect their work with the dominant infrastructure. Important work in care coordination is carried out by people working in community, like kaiawhina, community-based nurses, clinical nurse specialists and nurse practitioners. There were instances in this study where the long-term relationships that GPs and practice nurses held with members of community were significant in the provision of care. Nevertheless, there were many stories told of the people working outside of general practices establishing meaningful long-term relationships with people/patients with LTCs who had fallen out of relationship with general practices. It is commonly these community-based practitioners who are providing care-coordination roles rather than the GP located in the general practice. These community-based people undertake care coordination roles and then attempt to get people within the general practice to pay attention to what they have been doing. They make efforts to get their work documented in the medical records held by the general practice; however, they report struggles with making these connecting efforts. When they do make connections, it is often the practice nurse that they are able to establish a connection with.

The clinical nurse specialist at Site Two similarly talked about the efforts she put into care coordination. Although she is employed by the DHB, she held clinics both within the hospital context and within community contexts across the district. For her it is crucial to get to know who the GPs and practice nurses are within the general practices across the district where she works. In one example she comments on difficulties in care coordination where

she didn't know the clinicians at the "new general practice" described in Assemblage 5 of the narrative analysis of Chapter Seven.

9.5 Conclusion

Visible throughout this analysis is the perpetuation of the medical hegemony in PHC. In spite of the significant level of PHC which happens outside of general practices, time after time the powerful place held by the GP who is situated within the general practice is visible in this discourse analysis of ICP. Enrolment with a GP is the mechanism by which local populations are counted to enable the majority of PHC funding to flow to PHOs. Large portions of this funding flow to the general practice. GPs determine what kinds of ICP happen within the general practice, and with whom. Indeed, GPs also have significant influence on what ICP happens outside of the general practice through controlling processes of referral and engagement with community-based providers. GPs are seen as the coordinators of care and thus have oversight of referrals as well as being the recipients of laboratory results, and hospital discharge letters. The discourses of GP-centred ICP and business-centred ICP operate in tandem to strengthen this medical hegemonic structuring of PHC.

In spite of this dominance of GPs and general practices in PHC, a person-centred discourse of ICP perseveres. This person-centred ICP is much more closely aligned with the vision of the PHC Strategy 2001. Determined and tenacious practitioners located in community-based settings outside of the general practice (like those in iwi providers, pharmacies and the Wellbeing Support Team) are strongly influenced by a person-centred discourse of ICP. Discourses of RP strengthen this model of ICP, namely care-giving RP and team-based reflecting practice.

Many of the practitioners in this study, both inside and outside of the general practice, are frustrated that the potential of the PHC Strategy 2001 has not been realised. This is particularly noteworthy given that the sites of PHC chosen for this study were selected by iCOACH as there was evidence that innovative models of PHC were being implemented by practitioners in these places. In spite of this context, analysis of the texts in this study confirms Kearns (2018) conclusion that "most contemporary expressions of PHC are little more than primary medical care with a few nods to inclusiveness and population diversity" (p.244). It has been argued (Crampton et al., 2005; Gauld et al., 2019) that a number of PHC policy moves over the past two decades have been focused on reducing the

power of GPs in the health system and reconceptualising the place of general practices. The implementation of the PHC Strategy and the establishment of PHOs is identified as the most concerted effort to do so. In spite of these efforts, this research has shown that the general practice continues to be identified as the key organisation lying at the centre of PHC and GPs remain a powerful force influencing PHC.

Although there have been a series of changes to PHC funding and policy since the release of the PHC Strategy, none have significantly affected the central place of the GP and the general practice in the PHC system. Kevin, the GP working within the iwi provider describes his frustration with the perseverance of the medical hegemony:

> *The Primary Healthcare Strategy had all this potential. And yet all that happened was that people still had the same way of thinking and were just working under this strategy, but nothing changed. Talking about GPs, nothing changed the way in which they delivered care.*
>
> *It* [the PHC Strategy] *was about being capitated and about thinking proactively and think about reducing the burden of disease in your population. Instead, what we did is take the capitation and still have fee for service with our part charges. And kind of clip people's tickets as they walked through the door. Didn't change anything.* (Kevin)

Funding of increased points of patient contact with practice nurses and nurse practitioners increased, but these do not seem to have markedly shifted attention away from the GP and the general practice. The power of GP-centred ICP remains. The general practice continues to be the primary site where primary care is expected to occur. General practices define which practitioners are present (on-site) to provide PHC and which practitioners are absent. In essence the general practice defined what form PHC activity takes. GPs have significant influence on access to other parts of the health care system, acting as gate-keepers to diagnostic and specialist care and, as shown in this study, to community-service provision. Funding systems have created little impetus for GPs to collaborate with those outside of the general practice setting. This discourse analysis shows that changes to the ways PHC operate in this country will only be possible if there are changes to the way power is manifested in PHC.

Chapter 10 – Conclusions and recommendations

10.1 Introduction

Analysis in the previous three chapters has shown that the potential for an Alma-Ata inspired ICP to be woven into the infrastructure of the PHC of Aotearoa/New Zealand (as outlined in Chapter Six) has not yet been fully realised. This research has shown that although much ICP does happen, the centrality of the general practice exerts a constraining influence upon where it happens and its nature. This is of concern as the place of the general practice continues to dominate the PHC infrastructure of this country. As a result, practitioners outside of the general practice struggle within the PHC system to collaborate with those inside the general practice in meaningful ways. Nevertheless, practitioners outside of general practices persevere with their struggles knowing their efforts will benefit the people to whom they are providing PHC. The struggles of these practitioners support the findings of others that biomedicine continues to dominate provision of PHC within the main infrastructure of this country (Gauld, 2008; Gauld, 2013; Kusnanto, Agustian, & Hilmanto, 2018; OECD, 2020). Yet, this research also indicates some significant areas where future attention can be focused to strengthen the place of ICP in the PHC system of Aotearoa/New Zealand: health profession education programmes need to better equip our future PHC workforce in ICP; similarly they need to strengthen components of RP that are taught and weave these into the teaching of ICP; finally, the significant contributions to PHC made by practitioners and providers outside of the general practice need to be acknowledged and funded.

10.2 Discussion

Twenty years ago the implementation of the PHC Strategy 2001 led to the establishment of PHOs in this country. It has been argued that one motivation in this implementation was to shift the locus of PHC away from general practices towards community-based PHC (Crampton & Starfield, 2004; Crampton, 2019; Gauld, 2008; Gauld, 2013). Instead, the PHOs would provide the new organisational infrastructure of PHC, and would become enablers of all kinds of ICP amongst practitioners and providers. The findings of this doctoral research support the conclusions of others that implementation of the PHC Strategy did not succeed in bringing about this transformational change; Instead, the centrality and dominance of the general practice to PHC has remained and in many ways

been strengthened in the ways many PHOs emerged out of the independent practitioner associations (Crampton et al., 2005; Downs, 2017; Gauld et al., 2019). In this research on ICP this is particularly visible in the dominance of GP-centred ICP.

In Chapter Six (Section 6.2.4) Figure 8 shows the representation of the envisioned relationships between providers which were anticipated through implementation of the PHC Strategy 2001. In this figure a combined dashed/dotted line represents the envisioned relationships of 'agreements/collaboration and networks' amongst a collection of providers and practitioners. In this historic 2001 vision of the PHC system, general practices (named Practices in the diagram) are represented as 'Community and Non-Government Organisations' and placed alongside 'Health Clinics and Practitioners.' The general practices are conceptualised as having collaborative relationships with Māori providers and Pacific providers within a context of responding to the needs of communities and populations (in the diagram represented by a single dotted line). The PHOs are placed at the centre of these collaborative relationships and general practices are just one of multiple providers.

Instead of PHC being organised in this way, analysis discussed in the previous three chapters shows that general practices have retained a central place in the PHC infrastructure. The situation has not changed since Gauld (2013) earlier came to this same conclusion. This centrality of the general practice in PHC has impacted upon the potential for ICP. Within the general practice, it has been shown that the discourses of GP-centred ICP and business-centred ICP dominate. Whereas, person-centred ICP which aligns much more closely with the vision of the PHC Strategy 2001, primarily operates outside of the general practice and the purview of the GP.

One significant mechanism strengthening the place of the general practice in the PHC system is PHC funding. As shown in the previous chapter the power of GP-centred ICP, alongside business-centred ICP, conceptualises the general practice as owning patients. This ownership enables the general practice to secure the bulk of PHC funding. As a result person-centred ICP, which primarily operates outside of the general practice, has less secure access to this PHC funding. This separation of funding is a well-recognised barrier to the implementation of PHC outside of the general practice and is named by Tenbensel et al. (2017) as "the 'barbed-wire fence' that separates funding of medical and 'non-medical' primary care services" (p.1).

General practices are enabled through this funding to continue to implement their form of PHC which is in essence primary medical care (Kearns, 2007). Whilst this primary medical care holds an important place in the PHC system, this study indicates that continuing to identify the general practice as the main site of PHC is interfering with much potential for ICP. Yet, the place of the general practice as the locus of patient care, and controller of information about patient care continues to be supported by existing funding systems. This was evident in this study in the dominance of GP-centred ICP.

This situation is not unique to Aotearoa/New Zealand as evidenced by the OECD (2019) report on PHC across OECD countries which concludes that PHC is failing to achieve its full potential in terms of improvements in health outcomes and that one of the three contributing factors to this is "that the organisational model of PHC still mostly relies on face-to-face consultations with a physician who works in a solo practice" (p.27). The OECD goes on to argue that inclusion of other health professionals within the PHC organisational model, better teamwork with these professionals and better integration of care across the health and social service sector is required to enable PHC to realise its potential.

In Aotearoa/New Zealand practitioners and providers outside of the general practice strive to implement an Alma-Ata inspired PHC, as demonstrated in this study by the discourse of person-centred ICP. These practitioners are closely connected to family and whanau in their communities and also provide care and support to people in their homes. Engagement with family and whanau through clinics in community localities like marae and schools strengthen these connections. Yet, analysis in Chapters Seven, Eight and Nine shows their funding is not as secure as general practices. They do not have the same access to information systems to manage patients and patient care. Nevertheless, practitioners outside of the general practice strive to provide the best care they can and, consequently, are forced to invest in efforts to engage with general practices and GPs. Sometimes these efforts centre on getting their work outside of the general practice documented within the general practice system. Their efforts can also focus on re-connecting some patients with LTCs back to their general practices, knowing that is where the funding for these patients' care is situated.

An important finding of this discourse analysis is the way that the discourses of business-centred ICP and GP-centred ICP mutually reinforce each other. There are some aspects of this intersection which have been noted above with regard to PHC funding pathways strengthening the power of general practices. These findings add to Crampton's (2005) conclusions that for-profit general practice ownership leads organisations to operate

quite differently to those organisations that are community-governed non-profit practices. Crampton's (2005) analysis shows that community-governed non-profit practices tended to have lower patient fees, employ a wider workforce (e.g. community workers and midwives) and tended to employ more Māori and Pacific staff (Crampton, 2005). Broader diversity in staffing of the community-based non-profit practices was certainly evident in this research when considering the ICP identified in the iwi provider of Site One.

In addition to differences between general practices operating under different ownership models, Crampton (2005) notes that the relationship between not-for-profit PHOs and for-profit general practices has created problems. Crampton (2005) argues that PHOs are not able to exercise any real governance over general practices that are operating as private for-profit businesses; for example, with regard to influencing the general practice's setting of patient fees, or the general practice's decisions about staffing arrangements. This study has added a further example to the difficulties that PHOs can have in being able to influence the PHC that their member organisations provide. For example, the Wellbeing Support Team introduced in Chapter Seven was created by the PHO, yet, the Wellbeing Support Team themselves had to work hard with each general practice to convince them that they had something to offer which would improve care of the general practice's enrolled patients. The PHO was not able to bring much influence to bear upon general practices to assist the work of the Wellbeing Support Team.

Sitting alongside the two dominant discourses of GP-centred ICP and business-centred ICP was the third discourse, person-centred ICP. Although the place of this discourse was most visible outside of the general practice, this was not entirely the case. Social actors, including GPs, were engaged in social practices which demonstrated the presence of this discourse with one example being the employment of a social worker in the IFHC and the Medical Centre. In these cases knowledge that went beyond biomedicine was seen to be valued by some GPs, practice nurses and practice managers within general practices. Though much effort by those outside of general practices was often required to consolidate and make visible their contributions to practitioners inside general practices. Nevertheless, people within the general practices of this study came to highly value the work of those outside of the general practice, for example, the Wellbeing Support Team at Site Two and the gout project and the iwi provider in Site One.

The tensions between the three discourses of ICP identified in this study signal a key recommendation in being able to move forward into an alternate future where person-centred

ICP has a greater influence. In short, the relationship between PHOs and general practices requires significant re-working. Policy makers and funders need to recognise the ways that both business-centred ICP and GP-centred ICP mutually support each other and limit what kinds of ICP is possible. Being cognisant of these reinforcing discourses may lead in time to policy makers and funders bringing to bear further levers to change accepted practices which strengthen these discourses. In spite of the intentions of the PHC Strategy, Gauld (2008) describes instead the development of "a labyrinthine funding and organisational system with a variable capacity to deliver on the government's reform objectives" (p.93). Gauld's (2008) criticism was evident in this study with resultant detrimental impacts on ICP.

Alongside changes to policy, funding and organisational systems, this research signals that practitioners in general practices need to shift their understanding of the potential value that various practitioners outside of general practices can make to PHC. Finding ways for this kind of work outside of the general practice to be recognised, strengthened, supported and funded will be essential to shift discourses away from GP-centred ICP towards person-centred ICP. Central to this movement will be an ongoing recognition by those working in general practices that they do not have all the knowledge, all the practitioners, or all the control of the PHC that people in community need to have access to. A strength of this study has been ensuring that the narratives of ICP outside of the general practice are given as much attention as those inside the general practice.

Analysis has shown that person-centred ICP discourse values knowledge that goes beyond biomedicine. One of the most significant challenges to the power of biomedicine was issued by Engels (1977) more than forty years ago when he proposed the implementation of a biopsychosocial model to health arguing that biomedicine was reductionist and unscientific. The ongoing power of the discourse of biomedicine in PHC is evident in the fact that 40 years later PHC continues to struggle to implement this biopsychosocial approach (Kusnanto et al., 2018).

None of the practitioners in this research, either inside or outside the general practice are happy about the constraints imposed by the 10-minute appointments with doctors. Yet, as noted by the social worker at Site One, many people who come to the clinic don't even need to see the doctor. The discourse analysis of Chapter Nine highlighted the potential contributions that team-based RP can have upon the ways that PHC organisations manage their care. When there are practitioners within general practices other than GPs and practice nurses (like the podiatrist at the IFHC of Site One), there is an increased potential for team-

based RP within the organisation to enable interdisciplinary conversations to change this dynamic.

At the same time, these kinds of conversations between those within a general practice (GPs and practice nurses) and those outside are still possible. However, they require GPs and practice nurses to recognise that even though their role is important, implementation of a wider care model means their role does not need to be at the centre of all interactions. As noted by Kusnanto et al. (2018) doctors are not trained in the skills and knowledge required in carrying out comprehensive biopsychosocial evaluation, nor do they enough time to implement the resulting care from such evaluations. Some recognition by GPs of their own skills and knowledge alongside the competencies of practice nurses in biopsychosocial practice was evident in this study. This resulted in a strengthening of the ICP between GPs and practice nurses.

Similarly, GPs and practice nurses collectively recognised what they are not able to accomplish within the general practice and this encouraged them to support the involvement of others outside the general practice in the care of people with LTCs. Some recognition of this potential avenue of needed ICP was visible in the ways general practices ultimately were able to embrace the work of practitioners like the Wellbeing Support Team in Site Two, and the gout project and the work of the nurse practitioner at Site One. The more that the practice managers and GPs of general practices are able to invest time in relationships with these practitioners, the more time GPs will have to carry out the primary medical care they do with patients. After all, this is their area of expertise.

This research highlighted an unfilled potential for the role of nurse practitioners in PHC and the place that GP-centred ICP has been undermining this potential. The recent Health and Disability System Review (2020) clearly signalled a need for changes to the way care is provided care and how the health care workforce is used. They noted that New Zealand, similarly to trends in other countries, is experiencing significant and increasing clinical workforce shortages. They conclude: “Our system will not be sustainable unless we change models of care and use the workforce differently” (p.7).

The place of the nurse practitioner within the PHC workforce has long been signalled as potentially important as discussed in Chapter Six (Downs, 2017; Ministry of Health, 2002). Indeed, strengthening the role of nurse practitioners in PHC in other countries has been a significant aspect in the development of the PHC workforce (Downs, 2017). Downs

(2017) has argued that better co-ordinated primary care results from widening the multi-disciplinary team in PHC settings, and that having more nurse practitioners working alongside GPs is one way to do this: "Instead of focusing on expanding care provided by GPs, some positions, such as nurse practitioners, can take on functions previously performed by doctors. Nurse practitioners can also serve as alternative providers to GPs" (p.39).

For PHC in Aotearoa/New Zealand to truly realise the potential for ICP it has been shown in this study that the mutually reinforcing power of the GP-centred ICP and the business-centred ICP needs to be considered in the actions of policy makers and funders. Given the number of efforts over the past 90 years to challenge the influences of biomedicine on PHC it is likely that other mechanisms will also need to be brought to bear to shift the way PHC is organised. Only in this way can the discourse of a person-centred ICP be strengthened. Perhaps Aotearoa/New Zealand may yet find a way to embed the 20-year vision of PHC outlined in the PHC Strategy 2001 with its emphasis on ICP.

Insights from this study were possible due to a range of factors including the early decision to base the study on the critical hermeneutics of Kögler (1996; 1997a; Kögler & Stueber, 2000) and the resultant research design decisions. One of these key decisions was recognising the benefits of in-depth interviews with a range of practitioners involved in PHC. This led to some important insights into the ways different professionals see and experience ICP. The founding of this study on Kögler 's theory resulted in a decision to utilise the sociology of knowledge approach to discourse analysis (SKAD) of Keller (2005; 2013). The narrative analysis adopted in this study came from Keller's work. It provided a comprehensive analytic method to make sense of the wide range of confounding conceptualisations of ICP.

Adopting the SKAD also led to an early decision to attend to considerations of the place of PHC. Keller (2005; 2013) identifies the situational, institutional-organisational, and social contexts of texts being analysed as crucial to this SKAD approach. Attending to these factors ultimately resulted in the analysis outlined in Chapter Eight which proved crucial to the discourse analysis. Consultations with the socio-cultural geographer Dr Robin Kearns assisted with this approach.

Though some clear in-roads to understanding the complexity of ICP in Aotearoa/New Zealand were possible in the approach of this study, there are limitations to the conclusions that can be drawn. Two sites were chosen with each of these being informed

by the iCOACH study which was investigating innovative models of integrative care in community-based settings. This meant that practitioners in this study were already identified as going further than many other PHC providers in collaborative practices both within and across providers. ICP may not be enacted or understood in the same ways in other contexts. Nevertheless, looking back on my decision to step away from the iCOACH study, it appears this discourse analysis of ICP has opened up other areas of potential exploration that could shed light on future studies of innovative integrated care like iCOACH.

The nature of recruitment decisions led to engagement with four general practices in two different provincial towns. None of these four general practices were members of the larger PHOs in the country who are leading many changes to the way PHC operates. Nor were any of these general practices located in large cities which possibly have different mechanisms involved in ICP. Also, none of these four general practices were a part of organisations that were owned by not-for profit community organisations (e.g. Union Health Centres).

Other decisions were made to keep the study contained. The literature of ICP does signal the importance of collaborative practices between health care practitioners and patients/family members. Patients and their family members were not interviewed in this study. Similarly, the place of Pacific providers can be significant in some areas of Aotearoa/New Zealand but practitioners from these settings were not included in the study. Future studies could, therefore, be strengthened by considering some of the other contexts of PHC, namely the work that happens within the larger PHOs and work that happens in larger cities. Further consideration could also be made of the kinds of ICP that is situated within Pacific communities and provided by Pacific practitioners. This study also signalled the potential to consider ICP that happened between practitioners (particularly those operating outside of the general practice) and patients/family members.

10.3 Conclusion

The literature of ICP indicates better PHC is possible when practitioners of different professions, and those located in different providers, find ways to collaborate with each other. The participants in this study supported this idea. This discourse analysis has shown, however, that the often-researched biomedical discourse in health continues to confound what is possible in PHC within Aotearoa/New Zealand. The discourses of GP-centred ICP and business-centred ICP are strengthened by the biomedical discourse and shape what ICP

is possible. The power of these discourses continues to be reinforced by the ongoing dominance of the general practice in the PHC landscape.

Yet, in spite of the power of these combined discourses within the general practice, an alternate person-centred ICP continues to exert some influence upon PHC. This person-centred ICP is reinforced by the discourse of team-based RP which supports relationship-building amongst the practitioners who provide care. This form of ICP is much more in-line with an Alma-Ata vision of PHC which has operated in this country for a number of decades and tends to be located in community-owned PHC providers like iwi providers and union health centres.

Stories of hope and possibility about the ongoing potential of person-centred ICP came through strongly in the narrative analysis of this study. The message from these stories for a stronger PHC in this country has several interconnected pieces. The future PHC workforce needs to be trained in ICP and supported to implement these practices early in their careers. A key first step in this process is for every health profession education programme to recognise that ICP is an essential component in our future PHC system. This discourse analysis has also shown there are strong relationships between RP and ICP and so these programmes need to embed RP alongside ICP in their programmes. Additionally, it was clearly evident in this research that important PHC happens outside of the general practice and complements the primary medical care that happens within the general practice. Acknowledgement of the significance of these contributions to PHC requires some professional humility from those practitioners who are at the centre. Acknowledging, celebrating and funding the contributions of multiple practitioners and providers to the PHC system are essential steps towards realising the potential contributions that ICP can make to PHC in Aotearoa/New Zealand.

Appendices

Appendix A: Excerpts Referring to Reflective Practice in Documents of Professional Bodies of Health Professionals in Aotearoa/New Zealand

Incidences of reflection in the Medical Council of New Zealand (2018)'Recertification and continuing professional development' document

Section	***Quote***
In the introduction to the document they explain that '*a reflective, systematic approach to practice*' is a key aspect of their mandated authority under the Health Practitioners Competence Assurance Act (2003)	*These mechanisms include giving the Council power to require doctors to undertake programmed activities and* ***a reflective, systematic approach to practice****, designed to assist doctors to maintain safe and competent practice. (p.2)*
They name 'reflective mechanisms' in their vision for doctor recertification.	*Recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective,* ***efficient and reflective mechanisms*** *that support maintenance of high standards and continuing improvement in performance. p.3*
Reflection is named as an expectation in an example of a medical practice audit[34] provided in the section describing the compulsory annual 'Participation in audit of medical practice'	*Checking that cervical smear, diabetes, asthma, heart failure, lipid control and other procedures are done to pre-approved standard formats,* ***including reflection on the outcome, plans for change and follow-up*** *audit to check for health gains for that patient or group of patients. p.7*

A further example in the Medical Council of New Zealand (2018) documents appears in the template for the medical practice audit . Following the template, the following reflective questions are provided:

> *How did your practice change as a result? Please explain how you have responded /plan to respond to the outcomes of the audit. (Attach separate sheet, if necessary.) How will this impact on patient outcomes? How will you monitor that the action you have taken, has had a positive impact?*

[34] NB: Council requires that doctors have audit activity as a part of their CPD every year.

Incidences of reflection in the 'Competencies for Registered Nurses' document of the Nursing Council of New Zealand (2012)

Section	***Quote***
Competency 2.8	***Reflects upon**, and evaluates with peers and experienced nurses, the effectiveness of nursing care*
In the Glossary of Terms under the entry for 'Cultural Safety'	*The nurse delivering the nursing care will have undertaken a **process of reflection on their own cultural identity** and will recognise the impact that their personal culture has on their professional practice*
One of multiple indicators under Competency 1.5 – "Practises nursing in a manner that the health consumer determines as being culturally safe."	***Reflects on his/her own practice and values** that impact on nursing care in relation to the health consumers's [sic] age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability.*
One of three indicators under Competency 2.6 – "Evaluates health consumer's progress toward expected outcomes in partnership with health consumers."	***Reflects on health consumer feedback** on the evaluation of nursing care and health service delivery.*

Nurses are required to participate in either the recertification audit or a workplace approved PDRP As one component of demonstrating their continuing competence through the recertification audit, nurses must complete a 'Professional Development Activities Template' where they record their professional development activity and reflect on this activity by recording comments under this column heading: "Explain what you learnt from this activity – (you must explain how this activity affirmed or influenced your practice)".

Appendix B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Providers of primary healthcare and allied health for older adults

(Supplementary interview on collaborative practice)

Project Title: Implementing integrated care for older adults with complex health needs

Introduction

This study is about integrated models of primary care for older adults with complex health and social needs. We invite you to take part in a study exploring implementation of integrated community-based models of care.

You are invited to take part in this research because of your experiences and expertise as a provider of healthcare and/or social services. This study involves research with case study sites in Northland, Waikato and Canterbury. It is part of a longer programme of research which began in 2013 and will end in 2018. You have been invited to participate in this supplementary interview because of your involvement in collaborative practices with one of the case study sites we are researching. This supplementary interview is focused on collaborative practices amongst different professionals and the ways people reflect on these practices.

Your participation would involve you taking part in a face-to face interview (up to 90 minutes) at a time and place agreed with you. All providers will be reimbursed for reasonable costs associated with their participation. If you agree to take part in this study you will be asked to sign a Consent Form. More details are provided below.

Why are we doing this study?

Health and social care systems across western developed nations face the common challenge of providing appropriate, equitable, cost-effective care for growing numbers of older adults with complex needs. We are interested in identifying the components of successful innovative integrated models of community based primary health care that are responding to this patient group and identifying their processes of implementation. The study is being carried out in three jurisdictions with the aim of developing an understanding of what works, where, for whom and why. Additionally, we are identifying what is necessary to translate innovative models from one context to another.

Names of Researchers

Professor Toni Ashton, Karen Evison, Associate Professor Tim Kenealy, Professor Martin Connolly, Dr Peter Carswell, Associate Professor Nicolette Sheridan, Dr John Parsons, Dr Tim Tenbensel, Dr Ann McKillop, Cecilia Wong-Cornall, Andrew Lynch and Dr Lisa Walton.

Researcher Information

Karen Evison is National Programme Manager, Cardiovascular Disease/Diabetes and Other Long Term Conditions for the Ministry of Health. All other members of the research team are faculty or students in the Faculty of Health and Medical Sciences at the University of Auckland.

This research is funded by the Health Research Council of New Zealand. It is supported by Ki A Ora Ngātiwai (Northland), Hauraki Primary Health Organisation (Waikato) and the Canterbury Clinical Network (Canterbury), the principal organisations/networks for our three case study sites.

What would your participation involve?

Your participation is entirely voluntary.

If you participate, it would involve a semi-structured interview with you lasting up to 90 minutes. A small number of participants may be asked to take part in a followup interview to consolidate material from earlier interviews.

With your permission, the interview will be digitally recorded and the recording will be transcribed. If you agree to participate you will be asked to submit written consent prior to the interview. You will have the option to receive a paper copy of the transcript and will have the right to amend or remove any of your comments within two weeks of receiving this.

Possible benefits and risks to participation

By sharing your knowledge and experience you can contribute to the future implementation of community based primary health care services that are responding to the complex care of older adults.

Data Storage/Retention/Destruction/Future Use

By agreeing to participate in this study, you agree that all paper and electronic data, including digital audio recordings from this study, will be kept by the research team for a period of six years. To protect your identity, the data will be kept separately from your signed consent, securely and anonymously password protected computer drives, portable hard drives, or in locked cabinets at the University of Auckland. All data will only be accessible by members of the research team. All data will be shredded or erased after a period of six years.

Data gathered from these interviews will assist us in understanding how and why models of care for older adults with complex needs have been developed and implemented in New Zealand. Results will be disseminated in summary form to all interested parties and will be reported in presentations at

conferences and published in academic journals. Feedback to the research sites will be provided by the research team in the form of presentations and discussions.

Right to Withdraw from Participation

Even if you agree to participate in this study, you have the right to withdraw your participation at any time during the interview. Participants also have the right to withdraw their data from the study for up to a period of two weeks after the interview, or up to two weeks after receiving a draft transcript (if requested).

Anonymity and Confidentiality

Your participation in this study is confidential. All data will be stored securely and separately from consent forms to ensure neither participant nor organisation are identifiable. Only the researchers will have access to the data. Any findings from these interviews will be reported in presentations, reports and publications in a way that will not identify you or your organisation as the source. However due to the small size of the New Zealand health system, and to your position within it, there is a possibility that others may be able to identify you.

For information or questions about this study, please contact the following people:

- Dr Tim Kenealy, School of Medicine, Faculty of Medical and Health Sciences

Contact details: Email: t.kenealy@auckland.ac.nz Telephone 09 373.7599

- Mr Andrew Lynch, Health System Section, School of Population Health

Contact details: Email: andrew.lynch@auckland.ac.nz Telephone 3737599 extn 86234

- Professor Toni Ashton, Health Systems Section, School of Population Health.
  Contact details: Email toni.ashton@auckland.ac.nz Telephone: 09 373 7599 extn. 86136

If you wish to talk to the Head of Department where this research is being conducted, contact:

Prof. Ngaire Kerse, Head of School, School of Population Health, University of Auckland.

Email n.kerse@auckland.ac.nz Telephone: 09 3737599 extn. 84467

To talk with someone who isn't involved in the study:

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Telephone: 0800 555 050

Fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

To talk about any queries regarding ethical concerns:

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 87830 or 83761, or you can email: humanethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12 November 2014, for three (3) years, Reference Number 013071.

Appendix C: Participant Consent Form

PARTICIPANT CONSENT FORM

Providers of primary healthcare and allied health for older adults

(Supplementary interview on collaborative practice)

THIS FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Project Title: Implementing integrated care for older adults with complex health needs (iCOACH)

Names of Researchers: Professor Toni Ashton, Karen Evison, Associate Professor Tim Kenealy, Professor Martin Connolly, Dr Peter Carswell, Associate Professor Nicolette Sheridan, Dr John Parsons, Dr Tim Tenbensel, Dr Ann McKillop, Cecilia Wong-Cornall, Andrew Lynch and Dr Lisa Walton.

I have read the Participant Information Sheet for providers of primary health care and allied health and have understood the nature of the research and why I have been selected for an interview. I have had the opportunity to ask questions and have had them answered to my satisfaction.

1. I agree to take part in this research.
2. I understand that the interview will take up to 90 minutes.
3. I understand that I am free to withdraw my participation at any time during the study. I understand that I can decline to answer any question in the interview or questionnaire.
4. I agree for the interview to be digitally recorded. I also understand that I can ask for the digital recorder to be turned off at any time during the interview.
5. I understand that any third party who transcribes my interview will sign a confidentiality agreement and will keep all files secure.
6. I understand that I can request a copy of the transcript of my interview and that I may remove or amend any or all of my comments from this transcript up to two weeks after receiving it.
7. I understand that I can withdraw any traceable data to me up to two weeks after the interview (or two weeks after receipt of the transcription if requested) and completion of the questionnaire.
8. I understand that any paper and electronic data will be kept securely and anonymously in locked cabinets and password-protected computer drives at The

University of Auckland, or on a portable hard drive, for a period of six years, after which all data will be shredded or erased.

9. I understand that I will not be identified in any publications or reports that arise from this study. I understand, however, that my identity could be inferred by readers.

Name: _____ [Please print]

Signature _____ Date: _____

Organisation name _____

Please tick the box that applies to you about receiving a transcript (paper copy) of your interview.

☐ I wish to receive a transcript of my interview

☐ I do not wish to receive a transcript of my interview

Please tick the box that applies to you about receiving a summary of study findings

☐ I wish to receive a summary

☐ I do not wish to receive a summary

Email or postal address for a copy of the transcript or summary of findings

_____

_____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 12 November 2014, for three (3) years, Reference Number 013071.

Appendix D: Practitioner Interview Guide – Interview on Collaborative Practice

Introduction

As we discussed earlier, this research is a part of the iCOACH project which is exploring integrated models of primary health care for older adults with complex health and social needs. The iCOACH study team want to understand which features of healthcare organizations play a role in shaping the implementation and success of new models of care. The focus of this interview is on practices of collaboration and reflection.

Before beginning my questions, can you tell me a little about your role and how it fits with the provision of health and social services for users of this service?

Okay, let's move on to consider the topic of collaborative practice.

<u>Collaborative Practice</u>

1. What does the term collaborative practice *mean* to you?
   {how important is it to your work, your world; is this meaning related to this organisation's understanding, or different; connected to your personal professional identity /culture?; do you translate the term 'collaoborative practice' into other concepts or words in your head?}
2. How did you come to understand collaborative practice in this way?
   {initial training; ongoing training; organisational expectations; policy documents; contractual documents; CME, CNE, CPD; college accreditation}
3. With whom would you most commonly collaborate in this way?
   { do you see this collaborative practice as involving people within/outside the organisation/within/outside your profession; is it about primary/secondary/tertiary care?}
4. As a way of considering some different kinds of collaborative practices I have listed some different contexts where people sometimes talk about collaborative practice with others:
   - Can you indicate whether collaborative practice commonly occurs in any of these contexts in your normal work

	Case management /review
	Diagnosis /assessment
	Treatment plans /management
	Drug choice /dosage /interactions /education /adherence
	Managing difficult /challenging situations with clients
	Establishing /reviewing practice guidelines
	Other _____

- Are there contexts other than these where collaborative practice occurs in your work?
- Can you make some comments about the mix of different professionals/staff/disciplines who would be a part of these collaborative practices?
- Are there any other forms of collaborating practices that we haven't talked about so far?

5. I'm particularly interested in hearing about the times that you collaborate with people from different professions to yours. Can you tell me about a particular example of one of these situations where you have collaborated with people from other professions to meet the needs of your patients/clients?
   - Why did you choose this example? {inside/outside the organisation/typical/atypical}
   - What were the contexts of this example? {required; contracted; desired by self; client-driven; complex; common}
6. What supported /facilitated this collaboration?

   {respect/values; leadership; socialisation/enculturation; particular relationship with…; role clarity because of….; cultural understandings of…; processes of team reflection; relationships with other orgs/MoUs; your personal professional identity; expectations of clients (eg rongoa)}

7. What barriers or difficulties did you encounter in this collaboration?

   {fear, threats to professional identity; comms difficulty; conflict management; competency frameworks; lack of trust; team dynamics }

8. What impacts did this collaboration have on practice? {positive and/or negative; patient care; improved networking; your workload; your practice; the practice of the care team? other?}
9. What words would you use to describe this kind of collaboration? {'teamwork'; 'collaborative practice'; networking; interprofessional collaboration; other? }

Okay, let's move on to consider the topic of reflective practice.

Reflective Practice

10. What does the term reflective practice *mean* to you?

    {Prompts as needed: reflective thinking; learning from experience; reflection-in-action; reflection-on-action; critical reflection – examination of hidden assumptions so as to re-work our ideas and our practices; reflexivity – place of self in the knowledge we use, recognise and develop; other?}

    Definition (if required):

    Practitioners in the health and social services often talk about being on a lifelong journey of improving their own practice. It is thought that reflection is an important mechanism to contribute to this improvement. I am interested in exploring your ideas on this.

11. How did you come to understand reflective practice in this way?

    {Prompts as needed: initial training; ongoing training; organisational expectations; profession re-accreditation expectations; professional competencies; exposure to other professional understandings of reflective practice; own personal journey of… stress/health/counselling}

12. In the following list I have identified some common ways that people engage in reflective practice.

    - Can you identify which of these, if any, you would engage in within a normal working month.
    - Choose as many as are relevant for you

	peer supervision
	professional supervision
	Balint group
	client/patient/case reviews
	team reviews
	informal conversations with colleagues exploring practice /decisions /thinking
	formal consultations with practice or clinical manager
	personal practice journal
	time alone to critically reflect upon practice /decisions /thinking / processes
	re-accreditation/re-certification processes (including documenting material in your portfolio of practice)
	clinical audits
	PDSA cycles
	Other (please describe):_____

- Are there any other ways that you engage in reflective practice?

Let's look a little more closely at this topic of reflective practice. Some people think it is helpful to separate out reflective practice into individual reflective practice and more collective reflective practice. In the next set of questions I have would it be alright to do this?

{Y/N….why?}

To begin with, then, the next few questions focus on your individual reflective practice.

Individual Reflective Practice

13. Can you give me an example of when you have engaged in reflective practice?
14. In the past month, what encouragements or supports enabled you to engage in reflective practice?
15. In the past month, what barriers or difficulties did you encounter which affected your ability to engage in reflective practice?
16. Thinking about the reflective practice you have engaged in over the past month – In what ways might this reflective practice have impacted on your work {positive and/or negative; clients; professional practices; work with others}?

I'm also interested in the ways that you get together with others to reflect on your work as a group or as a team. The following questions are focused on this collective reflective practice.

Collective Reflective Practice

17. In the following list I have identified some common ways that people engage in *collective* reflective practice.
    - Please identify which of these, if any, you would engage in within a normal working month
    - Choose as many as are relevant for you

	peer supervision
	team supervision
	Balint groups
	Client/patient/case review meetings
	team review meetings
	informal conversations with colleagues focused on improving practice
	Other (please describe):_____

- Are there any other ways that you engage in collective reflective practice?

- Can you tell me a bit more about the focus or purpose of these collective reflective processes?
  {improving quality; cornerstone accreditation; improving client experiences; complaint; critical incident}

18. I'd like to hear more details about a specific instance of your experience of collective reflective practice. Can you tell me about a particular example where you have reflected on your work as a group/team?
    - Why did you choose this example?

      {typical/atypical; shows…; complex…}

    - What were the contexts of this example?

      {required; contracted; desired by self; client-driven}

19. What encouragements or supports enabled you and your colleagues to engage in this collective reflective practice?

    {reviews; accreditation; regular agenda item on a monthly meeting; development over time of a focus on team development}

20. What barriers or difficulties have you or your colleagues encountered that affect your ability to engage in this collective reflective practice?
21. What have been the effects on the work of you or your colleagues of this collective reflective practice?

    {impacts on provision of services; impacts on you as a professional; impacts on your team functioning}

22. What relationships do you see between reflective practice and collaborative practice?
    - Have your collective reflective practice processes contributed to collaborative practices in your work?
    - How important are these relationships between reflective practice and collaborative practice compared to other practice considerations?
    - How/when did you become aware of these relationships?
23. Are there any other things you'd like to tell me about reflective practice or collaborative practice as they relate to your work?

Appendix E: Space, Place and Time – Fieldwork Observations

Physical space lens - what values, beliefs and feelings are communicated in both the architecture and the way it is used? What stories does the physical space evoke?

- design factors - does this appear to facilitate or impede collaboration?
    - of staff within 'rooms'?
    - with people seeking assistance and the people who accompany them?
    - of other people who want to 'connect' with the service and its purpose?
    - are there obvious spaces to allow/encourage 'welcoming', 'collaboration'?
- built infrastructure
    - physical access and 'comfort' - desks, doors, steps, chairs
    - imagery, colours, warmth
    - materials - stone, wood, glass, metal
    - decor - 'European', Māori , Pacific, old, modern
    - sense of size/space leading to 'intimidation' or 'relaxation?
    - water, tea, coffee, food
- temporal-spatial constraints
    - how is time manifest? Do some people appear to spend more or less time with the people seeking assistance? where/why/how?
- how do people who come in to the service get 'channelled/moved' through the physical space/process?
- Do some people appear to have 'rights' regarding use of space?

Cultural/interpersonal dimensions lens - how do people behave, interact, dress, move?

- use of language and manifestation of professional/interpersonal power
- does it appear there is common recognition of values and purpose?
- sense of conviviality
- how do people communicate with each other
- are people who come in 'valued'? /how are they 'seen'?
- how are water, tea/coffee, food 'seen' /'managed'?
- what impressions of the workforce and service users come across
    - old, young, youth, New Zealanders, Māori , Pacific
- do these impressions seem to 'affect' the people coming in to the rooms

Intersections of above - who/how/space/place

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