

# Ten Lessons in Collaboration

[Deborah B. Gardner PhD, RN, CS](#)

## Abstract

Collaboration is a substantive idea repeatedly discussed in health care circles. The benefits are well validated. Yet collaboration is seldom practiced. So what is the problem? The lack of a shared definition is one barrier. Additionally, the complexity of collaboration and the skills required to facilitate the process are formidable. Much of the literature on collaboration describes what it should look like as an outcome, but little is written describing how to approach the developmental process of collaboration. In an attempt to remedy the all too familiar riddle of matching ends with means, this article offers key lessons to bridge the discourse on collaboration with the practice of collaboration. These lessons can benefit clinical nurse managers and all nurses who operate in an organizational setting that requires complex problem solving.

**Key words:** collaboration, constructive conflict resolution, emotional conflict, goodwill, shared power, task conflict, teamwork

Open any newspaper, business, economics, or professional magazine and the word collaboration is visibly noted in headlines, article titles, editorials, and even in advertisements. Its virtues are extolled. The nursing and health services management literature, and to a lesser extent medical literature, on collaboration is extensive (see literature review by [Sullivan, 1998](#)). Many researchers have validated the benefits of collaboration to include improved patient outcomes ([Knaus, Draper, Wagner, & Zimmerman, 1986](#)), reduced length of stay ([Rubenstein, Josephson, & Weiland, 1984](#)), cost savings ([Barker, Williams, & Zimmer, 1985](#)), increased nursing job satisfaction and retention ([Baggs & Ryan, 1990](#)), and improved teamwork ([Abramson & Mizrahi 1996](#)).

The focus on benefits of collaboration could lead one to think that collaboration is a favorite approach to providing patient care, leading organizations, educating future health professionals, and conducting health care research.

Unfortunately, interdisciplinary collaboration as a practice norm is rare. This may reflect the myriad contextual forces that hold more traditional practice norms in place for both individuals and practice organizational settings. It has been my observation over the past 25 years that effective collaboration is dependent on the context including my own frame of mind. Other contextual elements that influence the formation of collaboration include time, status, organizational values, collaborating participants, and type of problem.

---

...interdisciplinary  
collaboration as a  
practice norm is rare.

In hindsight, my initial experience with successful collaboration occurred as an undergraduate nursing student working with a favored nursing instructor whose

willingness to partner created a culture of empowerment and challenge. It would be over ten years before I appreciated that I had been afforded such a positive collaborative experience so early in my career. Later, writing about conflict and power use in interdisciplinary health care teams, and working with a collaborative interdisciplinary education program, provided a deeper, more complex understanding. What I have since learned is that the theoretical knowledge, while important, provides little guidance in terms of "how" to grow and sustain collaborative partnerships. Axiomatically, it is much easier to talk about it than to do it. The purpose of this article is to offer key lessons in collaboration, based on both relevant literature and my experience, which may benefit clinical nurse managers, and all nurses who work in an organizational setting that requires complex problem solving.

### **What is Collaboration?**

Collaboration is an intricate concept with multiple attributes. It is defined in a variety of ways, many of them explicitly referring to interdisciplinary collaboration ([Henneman, Lee, & Cohen, 1995](#)). Attributes identified by several nurse authors include sharing of planning, making decisions, solving problems, setting goals, assuming responsibility, working together cooperatively, communicating, and coordinating openly ([Baggs & Schmitt, 1988](#)). Related concepts, such as cooperation, joint practice, and collegiality, are often used as substitutes. They share some, but not all, of collaboration's attributes.

Teamwork and collaboration are often used synonymously ([Thomas, Sexton, & Helmreich, 2003](#)). Baggs and Schmitt ([1988](#)) reframe the relationship between collaboration and teamwork by defining collaboration as the most important aspect of team care, but certainly not the only dimension. The description of collaboration as a dynamic process resulting from developmental group stages ([Gray, 1989](#)) and as an outcome, producing a synthesis of different perspectives ([Cary, 1996](#)) more accurately reflects the reality that collaboration evolves in partnerships and in teams. The overlap between team/group process and collaboration is related to the nature of collaboration as a developmental process. Baggs and Schmitt ([1988](#)) reframe the relationship between collaboration and teamwork by defining collaboration as the most important aspect of team care but certainly not the only dimension.

From an inter-agency context, Gray ([1989](#)) explores collaboration as a process by framing it in three phases: problem setting, direction setting, and structuring. During the problem-setting phase stakeholders negotiate their right to participate. Agreement on the problem and what actions and resources are needed to address it are established during the direction setting phase. During the structuring phase, those agreements are implemented by allocating roles, responsibilities, and resources.

A more robust description of the concept of collaboration is derived by integrating Follett's outcome-oriented perspective ([1940](#)) and Gray's process-oriented perspective ([1989](#)), is offered below. Both authors strengthen the definition of collaboration by considering the type of problem, level of interdependence, and type of outcomes to seek. The following description of collaboration is based on the work of both Follett and Gray:

Collaboration is both a process and an outcome in which shared interest or conflict that cannot be addressed by any single individual is addressed by key stakeholders. A key stakeholder is any party directly influenced by the actions others take to solve a complex problem. The collaborative process involves a synthesis of different perspectives to better understand complex problems. A collaborative outcome is the development of integrative solutions that go beyond an individual vision to a productive resolution that could not be accomplished by any single person or organization.

This conceptualization of collaboration, which recognizes that collaboration is both a process (a series of events) and an outcome (a synthesis of different perspectives), will guide the lessons described in this article.

### **Essential Competencies for Collaborative Partnerships: Ten Lessons**

The critical need to work effectively with other health care disciplines has been discussed repeatedly in nursing literature. However, the question remains: How can we collaborate more effectively? Based on experience and current literature, ten key lessons are outlined below, and summarized in [Table 1](#), to provide some direction for putting collaboration into practice.

#### ***Lesson #1: Know Thyself***

Social science research helps us understand that each person brings a set of biases, values, and assumptions to all situations. Each of us has a map or mental model inside our heads that creates meaning for the things we experience. This mental model carries many assumptions, values and thus, expectations. Since it is impossible for one person to absorb all input and still take action, a mental model is developed as a selection process that pulls out specific but limited data. This mental model allows us to make sense of the world by selecting out information based on our knowledge, skills, experiences, and values. We work very hard to match the experiences we have with our mental models. We have mental models, for example, for music, for football, for other people, for ourselves, and for collaboration.

---

**Our individuality mediates our models...Each person in the organization will have a somewhat different mental model of how the collaboration will proceed.**

Often there are commonly shared mental models for more simple concepts, such as a chair or a flower. However, the more complex the concept, the more divergent mental models can be. Collaboration is initially based on individual mental models. For collaboration to become a shared mental model, partners and teams must tease out what a collaborative process entails and what outcomes are expected. Fleshing this out along the way is critical to the process, as our individuality mediates our models. Each person in the organization will have a somewhat different mental model of how the collaboration will proceed. This individual process is complex and partially explains why there are many different realities that simultaneously exist

[\(Senge, 1990\)](#).

Shared values and goals are a foundational part of the overarching mental structure that drives collaborative efforts. Therefore, it is important to evaluate personal goals and values, and to make them explicitly conscious. This requires the dualistic pursuit of self-knowledge and knowledge of others' mental models. A regular practice step is to be reflective. This requires frequent inquiry to recognize your values and priorities both professionally and personally. For example, do you know what type of interpersonal style you use in relating to patients and colleagues? Do you observe whether your actions align with your values and priorities? Do you know your "hot buttons?" This term, "hot button" is often used to describe a strong emotional or knee-jerk reaction, one that any person can have when perceiving that a key value is being degraded or disrespected. Lack of awareness of these hot buttons, or emotional drivers, limits the ability to proactively respond to difficult situations in constructive ways.

The current context of different mental models of collaboration and status differences between team members, combined with the need to communicate regularly to reach agreements, reflects the complexity of skill and effort needed for effective collaboration. There are no easy answers or shortcuts. Patience and a genuine interest in self-inquiry are requisite. The appreciation that each of us carries a different mental model links to the next lesson on valuing diversity.

### ***Lesson #2: Learn to Value and Manage Diversity***

Because nursing is one of the most gender-structured occupations in the United States, gender communication becomes a diversity element critical to understand if collaborative efforts are to be strengthened. Generally, men are more task oriented and women more relationship oriented ([Tannen, 1990](#)). While it is dangerous to stereotype gender communications in absolute terms, ignoring differences is equally dangerous. Collaboration requires a focus on both task and relationships. Coeling and Wilcox ([1994](#)) surveyed nurses and physicians to explore communication dimensions that impact collaboration. They focused on communication elements, including content (what is said), relationship styles (delivery of content and how the sender perceives the relationship with the other party), and time (amount of time needed for a good communication process to develop). Their analyses revealed that physicians and nurses place a high value on collaboration but different priorities on the communication elements.

---

While it is dangerous to stereotype gender communications in absolute terms, ignoring differences is equally dangerous.

In the Coeling and Wilcox study ([1994](#)), physicians focused primarily on the content aspect of the message (what was said) and nurses placed more value on the relationship aspect of the message (relationship style). While physicians reported factually organized data on patients (content) as the most important element in communicating with nurses, nurses selected affirming communication, such as acknowledgment of ideas and efforts

(relationship style), as most important. For example, a physician was more likely to focus on lab results and what actions to take, seldom acknowledging verbally the value of the information contributed by nurses. Understanding this contrast in communication emphasis between nurses and physicians can increase self-awareness regarding the assumptions or interpretations we make in our interactions with other team members. Learning more about gender communication can strengthen any nurse's communication repertoire. Gender communication is an example of a social pattern that adds diversity and knowledge to the interaction and thus enhances collaboration.

The invisible strengths of cognitive diversity must be optimized. Researchers have noted for some time that a team's cognitive capability is related to its cognitive diversity. Greater diversity can provide the potential for greater capacity for making complex decisions, where varied interests need to be balanced. Without diverse perspectives, no synthesis can occur and decision quality suffers ([Amason, 1996](#); [Murray, 1989](#)). An appreciation of cognitive diversity must be put into action if communication is to be effectively focused on true collaboration. However, it takes a conscious effort to optimize diversity. It is said that people like people like themselves. It is natural to be initially more comfortable with people who have similar work styles and experiences as ourselves. Often in a group situation comfortable connections are made and group norms are established; but the opportunity to optimize collaboration with different team members is often missed. This lack of seeking diversity of perspectives can unintentionally lead to exclusiveness and diminished use of available professional resources. This exclusionary practice has been labeled a negative side of collaboration ([Cooke & Kothari, 2001](#)).

---

Appreciative inquiry is a theory and approach...[that focuses] on the positive strengths of an organization and the possibilities rather than problems.

Appreciative inquiry and dialogue are communication methods that can facilitate greater collaboration efforts. Appreciative inquiry is a theory and approach ([Cooperrider & Srivastva, 1987](#)) used in organizational development to focus on the positive strengths of an organization and the possibilities rather than the problems. Multiple stakeholders with differing perspectives are asked to work together and develop a shared vision, strategies for implementation, and assessment of gains. This communication approach is one of active listening, positive regard for differences, and the belief in multiple realities. Visioning together what would be possible and how to get to such improved outcomes is different from a problem solving-approach.

Dialogue is another communications process that facilitates thinking and questioning together. In dialogue, conversations focus on surfacing assumptions, goals, and values, and summarizing disparate ideas in search of connections. This type of strategic conversation allows for further exploration and clarification of different vantage points, thus allowing for the development of new knowledge. Information sharing is increased and expertise within the group begins to surface, leading to a new valuation of difference as a context for innovation ([Isaacs, 1999](#)). Few team leaders possess the depth of

communication skills required to facilitate appreciative inquiry or dialogue. Adding such a facilitator at key junctures in the collaborative process could result in powerful and new outcomes.

Listening to and observing team members to better recognize their values, goals, and ways of communicating are critical actions to engage in, if mutually beneficial partnerships are to develop. This takes time and effort. Formal and informal interactions can be opportunities for learning about the diversity of styles and perceptions within a team.

### ***Lesson #3: Develop Constructive Conflict Resolution Skills***

The inevitability of conflict among collaborating parties has been well documented since the time of Florence Nightingale ([Jones, 1993](#); [Kalish & Kalish, 1977](#); [O'Neill, 1990](#)). Effectively integrated health care delivery models provide opportunities for collaboration at multiple levels: the interdisciplinary level, the intra-organizational level, and the inter-organizational level. However, this multi-dimensionality of today's health care delivery also opens the door for multi-faceted conflicts. This complexity gives added impetus to nurses to learn constructive conflict-negotiation skills.

Despite longstanding concern over ineffective conflict management, it continues to dominate. It may be the most critical obstacle to effective collaboration ([Abramson & Rosenthal, 1995](#)). Many professionals have not been socialized to understand the potentially positive aspects of conflict and to recognize that positive affective relationships and conflict are equally important to effective decision making ([Amason, 1996](#)).

---

Conflict can both hinder and facilitate collaboration.

Because nursing and medicine reflect two different cultures with differing practice visions, conflict can be expected between them. The professional socialization of medicine stresses "cure related" activities and that of nursing stresses "care related" behaviors ([Mauksch & Campbell, 1985](#)). Current investigation of doctor-nurse interfaces related to clinical treatment issues found many examples of contested inter-professional boundaries, but little evidence of overt conflict and/or negotiations. Nurses reported that they often manage their role to minimize any conflict. They reported difficulty speaking up and disagreements not being resolved to their satisfaction as primary barriers to collaboration ([Allen, 1997](#); [Thomas, Sexton, & Helmreich, 2003](#)).

Conflict resolution is the cornerstone of collaborative success. The nature of conflict, like that of collaboration, is complex. Conflict can both hinder and facilitate collaboration. When using conflict to facilitate collaboration, it is helpful to distinguish between emotional conflict and task conflict. Emotional conflict centers around relationships between individuals and can evolve from a task conflict. Task conflict centers around judgmental differences about how to achieve a common objective. Task conflict is often easier to address than emotional conflict. A cognitive debate over how to approach a task

can facilitate development of a shared understanding and create the necessary perspective for problem solving ([Jehn, 1995](#)).

---

When emotional conflict is experienced within a partnership context, it needs to be discussed, not avoided.

Collaborative leaders must be able to facilitate debate (conflict) over task issues and promote the expression of different perspectives concerned with how problems are defined and approached. If emotional conflict and personal issues surface within the team context, leaders need to be able to redirect concerns away from a personal level to the task issues. It is expected that the persons involved in personal issues will resolve these matters outside of the group discussion. Group intervention should only come if the interpersonal conflict begins to consistently disrupt the teamwork. When emotional conflict is experienced within a partnership context, it needs to be discussed, not avoided.

Specific cues or words that are leading to the conflict are most effective when giving this type of feedback. An example might be to reference a tone of voice or lack of eye contact. How non-verbal communications are being interpreted and how those messages are impacting the receiver being presented can provide a base for exploring the conflict.

Follet ([1940](#)) described another important consideration for conflict resolution. She explained that conflict is resolved, not by one side dominating the other, or by compromising, but by a creative integration that meets the differing needs of the collaborating parties. Cognitively, rather than thinking of alternatives that lock into either/or situations, a collaborative approach develops a synthesis of perspectives to invent a third alternative. This synthesis of perspectives is the desired outcome of collaboration.

While many books have been written about conflict negotiation. One that has stood this test of time is the Harvard Negotiation Project based on 15 years of research focused on a collaborative approach to constructively resolving conflicts ([Stone, Patton, & Heen, 1999](#)). This project provides a useful model for handling conflict by offering stages for conflict resolution. These stages include: using reflection to prepare one's self, starting a difficult conversation, and keeping it focused no matter how the other person responds. This process is particularly effective in one-on-one situations.

#### ***Lesson #4: Use Your Power to Create Win-Win Situations***

Unfortunately, conflict resolution is often focused on the single power concept of dominance. Dominance is a victory of one side over another. However, dominance is not successful in the long term for building commitment because the side that is defeated will wait for a chance to dominate. It is an automatic response to use dominant power, such as formal position, when conflict surfaces. Often this behavior lies outside one's awareness. Dominant power is incompatible with the integration of multiple perspectives, so critical to solving complex problems like those in health care today. It creates a win/lose

environment and leads to the persistent creation of unacknowledged, uneven discussions where one side dominates and difference is silenced.

The dominant power-oscillation-without-development scenario has been illustrated by Raven and Kruglanski (1970). They studied how two parties try to influence each other during a conflict. These authors observed that when both parties used coercive (dominant) power, there was greater distancing, greater distrust, and greater attribution of negative qualities to the other while holding oneself in higher esteem. In contrast, when both parties effectively used referent (goodwill) power emphasizing their communality, less distancing, less distrust, greater cooperation, and de-escalation of conflict occurred.

---

Dominant power is incompatible with the integration of multiple perspectives...

Collaboration operates on a model of shared power (Gray, 1994). However, this does not mean equal formal power. Role status in hierarchical systems is an invisible structure that connotes a formal or dominant level of power, which creates a power imbalance between group members. To achieve collaboration, participants must have some form of mutual exchange. It is the task of one negotiating in a conflict to increase his or her potential for success by actively structuring for a more even power base.

French and Raven (1959) have identified a number of informal power bases, some of which include the power of information, expertise, and goodwill. A conceptualization of goodwill power is described in Figure 1, which has been developed by Gardner (1998). Goodwill power, described as respecting others and assuming noble intentions of others, enhances interdisciplinary collaboration and mediates or decreases the negative effects of task conflict on collaboration. Asking for opinions from quiet, less verbal participants can demonstrate goodwill and facilitate the sharing of power.

### ***Lesson #5: Master Interpersonal and Process Skills***

Both interpersonal and organizational skills are needed for successful collaboration. Important interpersonal attributes include clinical competence, cooperation and flexibility (Trickett & Ryerson Espino, 2004); self-confidence and assertiveness (Keenan, Cooke, & Hillis, 1998); patience to listen to one another's rationale and the ability to take risks (Stoep, Williams, Green, & Trupin, 1999); and the ability to operate in multicultural contexts, tolerate ambiguity, be self-reflective, and convey a value that places the patient and/or community needs above the needs of individual health care team members (Israel, Schulz, Parker, & Becker, 1998).

An organizational skill essential for collaboration is systems thinking, the ability to see the contextual situation from the perspective of the entire system. This perspective involves understanding the connections between the multiple factors (i.e., power structure, political forces, finances, and policies) that influence the development of complex problems, as well as that of a collaborative process. Systems thinking and all of the skills mentioned above take time to master. Their development is similar in rigor and complexity to that of mastering a clinical skill. Therefore, as a layer of understanding the contextual backdrop of collaboration, it is useful to recognize how organizational context and collaboration itself evolve over time.

---

An organizational skill essential for collaboration is systems thinking...

### ***Lesson #6: Recognize that Collaboration is a Journey***

---

Time and daily effort are required to identify and successfully engage in collaboration opportunities.

Time and daily effort are required to identify and successfully engage in collaboration opportunities. Research into the context of collaboration between agencies ([Trickett & Ryerson, 2004](#)) and reports from nurse-physician partnerships ([Coeling & Wilcox, 1994](#)) describe collaboration as an evolving relationship across multiple projects. Establishing rapport, clarifying expectations, and requesting feedback are strategies necessary to begin collaborative relationships. Each successive collaborative effort builds on previous collaboration experiences and provides a reference for future efforts. In collaborative relationships, success breeds success. Each subsequent success is a step in the journey of cumulative learning from each other.

Since a collaborative relationship evolves over time, limited time is a key barrier to these relationships. Physicians and nurses alike report concern for inadequate time to talk together. This lack of time to talk limits the opportunities to build rapport with each other. Trust-building opportunities increase in tandem with opportunities to communicate. Opportunities to present expertise are vital to building trust in clinical partnerships. Thus, making time for responsive face-to-face interaction to work out issues must be fostered if collaboration is to develop. Although not everyone will have as strong a desire to collaborate as you might have, don't allow negative responses to put a stop to your efforts.

### ***Lesson # 7: Leverage Multidisciplinary Forums to Increase Collaboration***

Shared decision making is one of the hallmark dimensions of collaborative practice. Clinical rounds and interdisciplinary team meetings are examples of pre-existing structures that utilize face-to-face interaction. Such interaction provides a potential launching pad for collaborative relationships and processes to develop. These forums have several functions, including opportunities for information sharing, learning, and

planning patient care. Participation in shaping, or at least being aware of the structure of such forums, can often aid collaboration in subtle ways.

Coombs (2003) suggests several strategies nurses can use to leverage their influence in structural forums. First, be physically present. Sit at the table or within the circle of discussion. These interfaces are opportunities to listen to others and to advocate for your patients; they are not the time to be doing other tasks. Making other work a priority over these forums can undermine collaborative efforts. The charge nurse or nurse manager can support staff, especially junior staff, by ensuring they are able to attend these forums. Second, be mentally present and prepared. Develop awareness of the agendas that are competing for attention. Know what team members value and be proactive in responding to different personalities when opportunities arise. Third, understand and use timing in group processes. Choose the best time for your input during these rounds or team meetings. This may seem obvious, but being proactive about being heard is often vital to communicating your idea. Don't assume that waiting until the end of a meeting or discussion to voice an opinion is regularly effective. Additionally, writing down important comments or ideas before or during the forum, so that you may more freely choose where they can fit into a discussion, is one approach to making sure your concerns are addressed.

### ***Lesson #8: Appreciate that Collaboration Can Occur Spontaneously***

Although it is often helpful to structure times for collaboration, it is also important to realize that sometimes the best collaborative experiences occur spontaneously. Consider an illustration in which a spontaneous conversation begins in the hallway. Soon one of the participants suggests the use of a whiteboard, and the conversation moves into a conference room where the idea being created can now be visually communicated to enhance a shared understanding. As synergy develops, an excitement begins as new connections are being made both within each participant as well as between them. Who has more power is not an issue. The exchange is the center of the excitement. Roles fade into the background and mutual discovery is in the foreground. The experience culminates with a shared commitment to take an agreed upon action.

---

...sometimes the best collaborative experiences occur spontaneously.

---

...new knowledge is created as people spontaneously begin to work together on complex problems...

Although such experiences are often fleeting, hard to explain to others, and even harder to re-create, it is important to recognize the benefits that can come from such spontaneous collaboration. Frequently, new knowledge is created as people spontaneously begin to work together on complex problems within a health care agency. This occurs because people learn from each other all the time. Health care professionals do not realize, at least consciously, what they learn from each other. Sometimes they don't even realize

that they learn from each other. It has been observed in product development teams that successful collaboration for innovative outcomes is often not conscious. Sometimes trying to make collaboration happen through structures such as task force meetings, may in fact decrease the capacity to collaborate ([Mintzberg et al., 1996](#)).

### ***Lesson #9: Balance Autonomy and Unity in Collaborative Relationships***

Collaborative interaction is not automatic. Most interactions tend to be more cooperative or more assertive in nature. Cooperation can be described as working to meet others' needs, whereas assertiveness is used to meet one's own needs. In contrast, collaboration involves mutual attempts to find integrative solutions that meet the needs of both self and others. In collaborative interactions, both parties' concerns are recognized and addressed; different perspectives are merged or bridged ([Thomas, 1976](#)).

---

**Collaborative interaction is not automatic.**

However, excessive merging can be unproductive. Close relationships may become closed relationships as positions and patterns of interacting become fixed. Collaborative efforts that result in tightly knit groups often view outsiders as the enemy, or can make outsiders feel like the enemy. A team that works together too long often reduces communication with outside people and begins to see only the virtue and superiority of its own ideas.

Hampden-Turner ([1970](#)) defined synergy as an optimal balance between individualism and integration. Too much autonomy and individualism can lead to isolation; yet too much integration can lead to diffusion. When this occurs, perspectives merge until parties have nothing new to offer each other. Should this occur, redirect focus on the individual force and adopt reflective practices, be willing to seek feedback, and admit mistakes. Collaboration is indeed a fine balance between autonomy and unity.

### ***Lesson #10: Remember that Collaboration is Not Required for All Decisions***

---

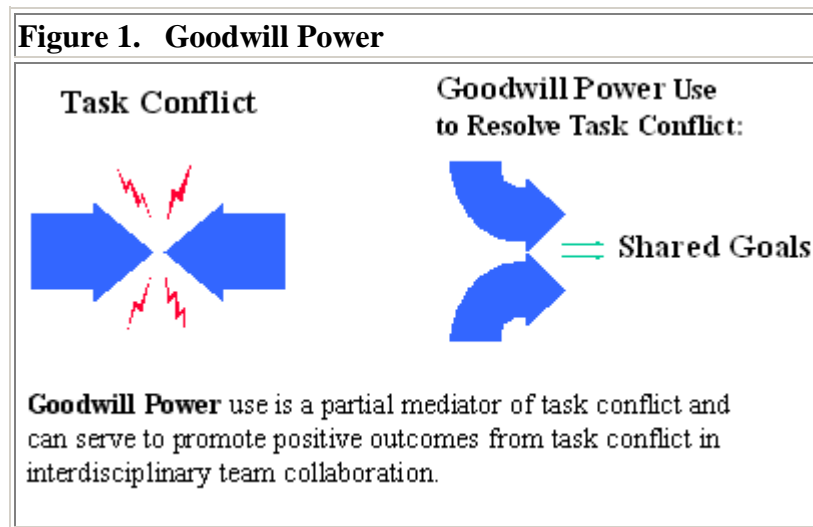
**Collaboration is best used to solve "wicked" problems...with imperfect, changing, or divergent solutions...**

When to use collaboration is a question worth exploring. Collaboration is best used to solve "wicked" problems. These are problems with imperfect, changing, or divergent solutions, such as the challenges associated with drug addiction or care for the chronically ill ([Trickett & Ryerson Espino, 2004](#)). The increasing complexity of the health care system and patient conditions, along with limited resources are increasing the number of wicked problems we face in health care today and the need for collaboration. However, collaborative relationships can be intense, unbalanced, and tiring.

Collaboration is not consistently good, nor pervasively beneficial; nor is it always needed. Not all problems are complex (Mintzberg et. al, 1996). Autonomous decision making still plays a vital role in quality health care delivery. Taking the time to provide group input into simple decisions may not be cost-effective. No one process, no matter how encompassing, fits all situations. Judgment is needed.

### Conclusion

Effective collaboration within nursing and with other health care professionals to achieve higher quality outcomes in an increasingly interdependent health care delivery system continues to grow in importance. Collaboration is a complex partnership. It is a process that occurs over time. It is also an outcome, a synthesis of different perspectives, an integrative solution. It is important to remember that conflict is a natural and expected part of collaboration. Conflict provides an opportunity to deepen agreement. The strategic use of conflict resolution skills and goodwill power can be effective in enhancing decision quality and team commitment. This article has offered ten lessons to enhance collaboration. Focusing on the value of collaboration can motivate health care professionals to apply these lessons in their daily practice.



**Table 1. Summary of Collaboration Lessons**

**Lesson #1: Know thyself.** Many realities exist simultaneously. Each person's reality is based on self-developed perceptions. Requisite to trusting self and others is in knowing your own mental model (biases, values, and goals).

**Lesson #2: Learn to value and manage diversity.** Differences are essential

assets for effective collaborative processes and outcomes.

**Lesson #3: Develop constructive conflict resolution skills.** In the collaborative paradigm, conflict is viewed as natural and as an opportunity to deepen understanding and agreement.

**Lesson # 4: Use your power to create win-win situations** The sharing of power and the recognition of one's own power base is part of effective collaboration.

**Lesson #5: Master interpersonal and process skills.** Clinical competence, cooperation, and flexibility are the most frequently identified attributes important to effective collaborative practice.

**Lesson #6: Recognize that collaboration is a journey.** The skill and knowledge needed for effective collaboration take time and practice. Conflict resolution, clinical excellence, appreciative inquiry, and knowledge of group process are all life-long learning skills.

**Lesson #7: Leverage all multidisciplinary forums.** Being present both physically and mentally in team forums can provide an opportunity to assess how and when to offer collaborative communications for partnership building.

**Lesson #8: Appreciate that collaboration can occur spontaneously.** Collaboration is a mutually established condition that can happen spontaneously if the right factors are in place.

**Lesson #9: Balance autonomy and unity in collaborative relationships.** Learn from your collaborative successes and failures. Becoming part of an exclusive team can be as bad as working in isolation. Be willing to seek feedback and admit mistakes. Be reflective, willing to seek feedback, and admit mistakes for dynamic balance.

**Lesson #10: Remember that collaboration is not required for all decisions.** Collaboration is not a panacea, nor is it needed in all situations

## **Author**

**Deborah B. Gardner, PhD, RN, CS**

E-mail: [dgardner@cc.nih.gov](mailto:dgardner@cc.nih.gov)

Deborah Gardner, PhD, RN, is the Chief of Planning and Organizational Development at the Clinical Center of the National Institutes of Health. Dr. Gardner has taught in several local graduate nursing administration programs. Promoting partnerships between academia and practice, she routinely precepts and mentors Presidential Management

Interns, graduate nursing students, and organizational development graduate students. In 2003, she received a federal award for "Innovations in Education" for the successful implementation of an organization-wide, competency-based customer service program for 3000 employees. Dr. Gardner has been a consultant and trainer with health care and business corporations, specializing in the facilitation of designing collaborative strategies for effective organizational outcomes. A primary focus is team and leadership development as well as structural redesign. She received her Doctorate of Philosophy in Nursing Administration and Health Policy from George Mason University, a Master of Science in Psychiatric Mental Health Nursing from the University of Hawaii, and a Bachelor of Science in Nursing from Oklahoma Baptist University. Dr. Gardner is certified in mediation and neuro-linguistics, and has published in the areas of interdisciplinary collaboration, organizational governance, and health policy.

## References

Abramson, J.S., & Mizrahi, T. (1996). When social worker and physicians collaborate: positive and negative experiences. *Social Work*, 41, (3), 270-281.

Abramson, J., & Rosenthal, B. (1995). Interdisciplinary and interorganizational collaboration. In: A. Minahan (Ed.), *Encyclopedia of Social Work*, 19th ed. Vol. II: pp. 1479-1489. Silver Springs, MD.: National Association of Social Workers.

Allen, D. (1997). The nursing medicine boundary: negotiated order. *Sociology of Health and Illness*, 19(4): 498-520.

Amason, A.C. (1996). Distinguishing the effects of functional and dysfunctional conflict on strategic decision making: resolving a paradox for top management teams. *Academy of Management Journal*, 39(1): 123-148.

Baggs, J.G., & Ryan, S.A. (1990). Intensive care unit nurse-physician collaboration and nurse satisfaction. *Nursing Economics* 8, 386-392.

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

Barker, W.H., Williams, T.F., & Zimmer, J.G. (1985). Geriatric consultation teams in acute hospitals: Impact on back-up of elderly patients. *Journal of American Geriatrics Society*, 33, 422-428.

Cary, A.H. (1996). Case management. In M. Stanhope & J. Lancaster (Eds.). *Community Health Nursing: Process and Practice for Promoting Health*, pp. 682-706. St. Louis: Mosby Year-book, Inc.

Coeling, H.V., & Wilcox, J.R. (1994). Steps to collaboration. *Nursing Administration Quarterly*, 18(4), 44-55.

Cooke, B., & Kothari, U. (Eds.). (2001). *Participation: the new tyranny*. London: Zed Books.

Coombs, M. (2003). Power and conflict in intensive care clinical decision making. *Intensive and Critical Care Nursing, 19*, 125-135.

Cooperrider, D.L., & Srivastva, S. (1987) Appreciative inquiry in organizational life. Research in *Organizational Change and Development*, Vol. 1, 129-169. Retrieved September 20, 2004 from [www.appreciative-inquiry.org/AI-Life.htm](http://www.appreciative-inquiry.org/AI-Life.htm).

French, J. R., & Raven, B. H. (1959). The bases of social power. In B. Cartwright. (Ed.), *Studies in Social Power*. Ann Arbor, MI: Institute for Social Research.

Follet, Mary, (1940). Content from Mintzberg, H., Dougherty, D., Jorgensen, J., & Westley, F., (1996). "Some surprising things about collaboration-Knowing how people connect makes it work better." *Organization Dynamics, 25*(1), 30-71.

Gardner, D. (1998). *Effects of conflict types and power style use among health professionals in interdisciplinary team collaboration*. University Microfilms International. (University Microfilms No. 9821639); 1998.

Gray, B. (1989). *Collaborating*. San Francisco: Jossey-Bass.

Hampden-Turner, C. (1970). Synergy as the optimization of differentiation and integration by the human personality. In: J.W. Lorsch & P.R. Lawrence, (Eds.) *Studies in Organizational Design*, pp. 187-196.

Henneman, E.A., Lee, J.L., & Cohen, J.L. (1995). Collaboration: A concept analysis. *Journal of Advanced Nursing, 21*, 103-109.

Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173-202.

Jehn, K.A. (1995). A multimethod examination of the benefits and detriments of intragroup conflict. *Administrative Science Quarterly, 40*, 256-282.

Jones, M.L. (1993). Role conflict: cause of burnout or energizer. *Social Work, 38*(2), 136-141.

Kalish, B.J., & Kalish, P.A. (1977). An analysis of the source of physician-nurse conflict. *Journal of Nursing Administration, 7*, 50-51.

Keenan, G.M., Cooke, R., & Hillis, S.L. (1998). Norms and nurse management of conflicts: key to understanding nurse-physician collaboration. *Research in Nursing and Health 21*, 59-72.

Knaus, W.A., Draper, E.A., Wagner, D.P., & Zimmerman, J.E. (1986). An evaluation of outcomes from intensive care in major medical centers. *Annals of Internal Medicine*, 104, 410-418.

Raven, B.H., & Kruglanski, A.W. (1970). Conflict and power. In P.G. Swingle (Ed.), *The Structure of Conflict*, pp. 69-109. Boston: Auburn House.

Isaacs, W. (1999). *Dialogue and the art of thinking together*. New York, NY: Doubleday.

Israel, B.A., Schultz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community – based research: assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173-202.

Levine, S. (1998). *Getting to resolution: turning conflict into collaboration*. San Francisco: Barrett-Koehler Publishers, Inc.

Mauksch, H.O., & Campbell, J.D. (1985). Political imperatives for nursing in a stereotyping world. *Perspectives In Nursing*, 1985-1987. NLN Publications, 41-1985, 222-229.

Mintzberg, H., Dougherty, D., Jorgensen, J., & Westley, F. (1996). "Some surprising things about collaboration-knowing how people connect makes it work better." *Organization Dynamics*, 25(1), 30-71.

Murray, A.I. (1989). Top management, group heterogeneity, and firm performance. *Strategic Management Journal*, 10, 125-141.

O'Neill, P. (1990). Ethical issues in field research: balancing competing values. *Canadian Psychology*, 31(2), 147-154.

Rubenstein, L.S., Josephson, K.R., & Wieland, G.D. (1984). Effectiveness of a geriatric evaluation unit: a randomized clinical trial. *North Eastern Journal of Medicine*, 311, 1664-1670.

Senge, P. (1990). *The fifth discipline: the art and practice of the learning organization*. New York: Doubleday Dell Publishing Company.

Stoep, A., Williams, M., Jones, R., Green, L., & Trupin, E. (1999). Families as full research partners: what's in it for us? *Journal of Behavioral Health Sciences and Research*, 26(3), 329-344.

Stone, D., Patton, B., & Heen, S. (1999). *Difficult Conversations: How To Discuss What Matters Most*. New York, N.Y.: Penguin Putnam Inc.

Sullivan, T. J. (Ed.) (1998). *Collaboration: a health care imperative*. St. Louis, MO: McGraw-Hill.

Tannen, D. (1990). *You just don't understand*. New York, NY: Ballantine Books.

Thomas, E., Sexton, J., & Helmreich, R. (2003). Discrepant attitudes about teamwork among critical care nurses and physicians. *Critical Care Medicine*, 31(3), 956-959.

Thomas, K. (1976). Conflict and conflict management. In: M.D. Dunnette (Ed.), *Handbook of Industrial and Organizational Psychology*. Chicago, IL: Rand McNally College Publishing Co.

Trickett, E.J., & Ryerson Espino, S.L. (2004). Collaboration and social inquiry: Multiple meanings of a construct and its role in creating useful and valid knowledge. [Electronic Version]. *American Journal of Community Psychology* 34(1/2), 1-64.

---

© 2005 *Online Journal of Issues in Nursing*  
Article published January 31, 2005

---

Gardner, D. (January 31, 2005). "Ten Lessons in Collaboration". *Online Journal of Issues in Nursing*. Vol. #10 No.1, Manuscript 1. Available: [www.nursingworld.org/ojin](http://www.nursingworld.org/ojin)

---

## Related Articles

- [A Collaboration Challenge: Interdisciplinary Clinical Research by Faculty in Non-Research-Focused Colleges and Universities](#)  
Sharon K. Broscious, DSN, RN, CCRN; Michele Darby, BSDH, MSDH; Karin Loftin. PhD (November 30, 2007)
- [Interprofessional Relationships and Collaborative Working: Encouraging Reflective Practice](#)  
Angela Ross, BSc (Hons) psychology RN, RM; Nigel King, BA (Hons) Social Psychology, PhD, CPsychol; Jan Firth, RN, DN, Dip.N(Lon), CertEd, M.Ed., DNT (January 31, 2005)
- [New Horizons for Collaborative Partnerships](#)  
Carol Boswell, EdD, RN; Sharon Cannon, EdD, RN (January 31, 2005)
- [Nurse-Physician Workplace Collaboration](#)  
Linda L. Lindeke PhD, RN, CNP; Ann M. Sieckert, BAN (January 31, 2005)
- [Collaboration: Leadership in a Global Technological Environment](#)  
Patricia Hinton Walker, PhD, RN, FAAN; Karen L. Elberson, PhD, RN (January 31, 2005)

20910

ISSN: 1091-3734 | 1-800-274-4ANA | [Copyright Policy](#) | [Privacy Statement](#)



**Imagine, nursing issues: in time, in depth, in OJIN.**

OJIN: The Online Journal of Issues in Nursing™ is a peer-reviewed, international, online publication that addresses pertinent topics affecting nursing practice, research, education and the wider health care sector. Both Medline and CINAHL index the journal.