School of Health Sciences, Jönköping University

Collaboration in Health and Social Care
Service User Participation and Teamwork in Interprofessional Clinical Microsystems

Susanne Kvarnström

SCHOOL OF HEALTH SCIENCES
JÖNKÖPING UNIVERSITY

DISSERTATION SERIES NO. 15, 2011
JÖNKÖPING 2011
Abstract

This thesis addresses the relationship between citizens and the welfare state with a focus on the collaboration between service users and professionals in Swedish health and social care services. The overall aim of the thesis was to explore how professionals and service users experience collaboration in health and social care.

Descriptive and interpretative study designs were employed in the four studies that comprise this thesis. A total of 87 persons participated in the four studies, including 22 service users and 65 front-line professionals. The research methods included focused group interviews, individual interviews and interactive participant reflection dialogues.

The first study describes the discursive patterns in the front-line professionals’ constructions of ‘we the team’ which positions the service user as both a member and a non-member of the interprofessional team. The second study surfaces the difficulties of interprofessional teamwork as perceived by professionals. The third and the fourth studies explore how service users and professionals construct and perceive the concept of service user participation. The findings show that collaboration in terms of service user participation cannot only be understood as contract relationships between consumers and service providers. Service users and professionals perceive that there are several other ways to act as a citizen and for people to exercise human agency in relation to the welfare state. This thesis shows that the various conceptions of service user participation in interprofessional practice encompass dimensions that include themes of togetherness, understanding and interaction within the clinical microsystem.

The findings of the four studies are discussed and used to create models that aim to conceptualise collaboration. These models can contribute to learning and improvement processes which facilitate the development of innovative service user-centered clinical microsystems in health and social care.
Original papers

The thesis is based on the following papers, which are referred to by their roman numerals in the text:

Paper I


Paper II


Paper III

Kvarnström, S., Willumsen, E., Andersson-Gäre, B., & Hedberg, B. How service users perceive the concept of participation, specifically in interprofessional practice (accepted for publication in British Journal of Social Work)

Paper IV

Kvarnström, S., Hedberg, B., & Cedersund, E. The dual faces of service user participation: Implications for empowerment processes in interprofessional practice (submitted)

The articles have been reprinted with the kind permission of the respective journals.
# Contents

Abstract ........................................................................................................................................ 3  
Original papers ....................................................................................................................... 4  
Contents ..................................................................................................................................... 5  
1. Collaboration in health and social care .................................................................................. 8  
   Introduction ........................................................................................................................... 8  
   Aim of the thesis .................................................................................................................... 13  
   Organisation of the thesis ...................................................................................................... 14  
2. Conceptual framework ........................................................................................................... 15  
   Service user participation and empowerment ........................................................................ 16  
   The interprofessional dimension of collaboration ................................................................ 21  
   Microsystem approaches to collaboration ............................................................................ 28  
3. Earlier research ..................................................................................................................... 32  
   Research interest and positionings in the thesis .................................................................... 42  
4. Methodology ........................................................................................................................ 45  
   Overview ............................................................................................................................... 45  
   Paper I .................................................................................................................................. 53  
   Paper II .................................................................................................................................. 56  
   Papers III - IV ......................................................................................................................... 59  
   The author’s contact with the field ....................................................................................... 64  
   Ethical considerations ........................................................................................................... 65  
5. Findings .................................................................................................................................. 68  
   Self presentations and discursive patterns (I) ......................................................................... 68  
   Perceived difficulties in interprofessional collaboration (II) ............................................... 70  
   Service users’ perceptions of service user participation (III) .............................................. 74  
   Professionals’ perceptions of service user participation (IV) .............................................. 76  
6. Discussion ............................................................................................................................... 81  
   Collaborative processes in clinical microsystems ................................................................. 82  
   Implications for health and social care practice ................................................................... 93  
   Implications for social citizenship ......................................................................................... 101
Methodological considerations .............................................................. 103
The relevance and contribution of the microsystem approach.......... 108

7. Concluding remarks and suggestions for further research........ 113
Suggestions for further research............................................................ 115

Summary in Swedish............................................................................. 117
Samarbete inom vård och omsorg ......................................................... 117
Acknowledgements ............................................................................. 124
References .......................................................................................... 126
I. Collaboration in health and social care

Introduction

This thesis addresses the relationship of citizens with the welfare state with a focus on the collaboration between service users and professionals in Swedish health and social care services.

Collaboration is connected to the modernisation of the health and social care systems that have taken place since the end of the 20th century (Scott et al., 2005). In Sweden and other Western European countries, there is an increased emphasis on citizens’ personal activity in their contact with the welfare state. Welfare state policymakers have combined benefit cuts with expressed values of human rights and citizen’s rights as well as with the obligations of citizens to exercise choice (Johansson & Hvinden, 2007a). The construction of the active citizen as responsive and full of initiative is distributed across the entire social field (Dahlstedt, 2008), and this is explored in this thesis in terms of service user participation and collaboration with front-line professionals. Collaboration between service users and professionals, as well as collaboration between various professionals, is an integral part of health and social care services. There is no question that service users should be involved; rather, the question is “how to ensure they are involved, both at the level of practice and at the level of strategic policy-making” (Whittington, 2003a, p. 47).

The active citizen and the active service user

The emphasis on the active citizen and the active service user is associated with social citizenship in terms of exerting one’s social rights to be a citizen
Social citizenship refers to the relationship of citizens with the welfare state, i.e. citizens’ rights and duties related to services designed to meet social needs and to enable citizens to pursue their life plans (Sheppard, 2006; Taylor-Gooby, 2008). Social citizenship is an element of citizenship, which also includes civil and political elements such as freedom of speech and the right to exercise political power (Marshall, 1992). Ideally, social rights enable citizens to exercise their civil and political rights on equal terms. However, citizenship rights are dynamic and always open to renegotiation and reinterpretation (Lister, 2003).

The rights and activities of citizens in their roles as health and social care service users are highlighted in Swedish law, which includes the Social Services Act (SFS 2001:453). The first article of the Social Services Act establishes that social services shall promote citizens’ active participation in society and, by taking into account people’s responsibility for their own and others’ social situations, shall focus on the liberation and development of the individual’s and groups’ own resources. Furthermore, the Act states that social services shall be based on respect for individuals’ right to autonomy and integrity (SFS 2001:453, 1§). In addition, according to the Health and Medical Service Act (SFS 1982:763), health care shall be based on respect for patient autonomy and integrity. Measures directed towards the patient shall be appropriately coordinated, and interventions shall, as much as possible, be designed and implemented in consultation with the patient (SFS 1982:763, 2§).

The ‘active citizen’ takes responsibility for his or her own welfare and acts by challenging professional discretionary power and paternalistic bureaucracy during contacts with health and social care services. ‘Active citizens’ consequently display less trust when services are administered and also demand more power when meeting with front-line professionals (Johansson & Hvinden, 2007a). Meetings between service users and professionals create arenas that enable citizens to take on this responsibility (Dahlstedt, 2008). Collaboration with professionals is thus attached to empowerment processes in that the professionals are expected to enable the service users to actively participate at the interactive practice level.
Specifically, the professionals are expected to create conditions in which marginalised individuals and groups can practice increased responsibility and power; ideally, in this arena, service users will be perceived and met as equals (Meeuwisse, 1999).

Contemporary health and social care is complex, and several actors co-exist with the service user. Collaboration with other professions is essential to professional practices, and working in teams is widespread (Whittington, 2003b). It used to be the case that citizen contact with the welfare state as a service user meant to meet with only one professional party, and the user’s and the professional’s respective roles and expectations were clear. However, this has developed in recent decades into a situation in which several front-line professionals are involved around each service user. The organisation of health and social care services is still progressing in terms of incorporating multiple actors and the actors’ roles and methods of communication with each other are often implicit rather than explicit (Batalden et al., 2006). Consequently, decisions are seldom made by one or two actors but are rather interwoven, involving several professionals who are acting according to different laws. The laws may be issued for a specific professional domain, but well-functioning health and social care often requires the shared efforts of a multitude of professionals. For example, social workers work closely with health care professionals in different branches, such as health visiting, community nursing, child protection and care for older persons (Leiba & Weinstein, 2003). In other words, active citizenship is often exercised in an interprofessional context. According to Braye and Preston-Shoot (1995), understanding interprofessional collaboration is vital for empowerment of service users as well as professionals. In this thesis, the arenas and expectations for active citizenship are thus considered in the context of various types of collaborations between service users and front-line professionals.

Customer-oriented perspectives

Development of active social citizenship is promoted by mutually reinforcing processes such as structures of governance and self-directed
citizen demands. The process is complex and corresponds to the withdrawal of a redistributive welfare state together with marketisation of welfare and increased individuality in society (Johansson & Hvinden, 2007a). Thus, several factors lend support to the idea that construction of active citizenship is linked to active service user participation in health and social care. The customer-oriented perspectives of the new public management (NPM) philosophy and service quality improvement approaches are described below, and these viewpoints are also reflected in Swedish laws and regulations. These perspectives, together with the perspective of citizenship rights described earlier, suggest various (and sometimes converging) approaches to changing the past relationships between service users and the professionals who act as representatives of health and social care services.

Since the 1980s, the Swedish welfare state has increased its focus on what has been called ‘consumer control’ (Möller, 1996). The performativity of the consumer/customer concept within service management implies that the individual is obliged to be active (Nordgren, 2008). For example, the NPM philosophy, which has greatly influenced Swedish health and social care services, is characterised by elements such as customer orientation, contract steering and performance measurement (Agevall, 2005). Within the NPM philosophy, activity and citizen empowerment are constructed in terms of the changed relations between service users and professionals: citizens are gaining more influence in relation to public services and front-line professionals as empowered customers that are “able to choose between the ‘shops’ of public agencies,” (Agevall, 2005, p. 24). Internationally as in the UK, the NPM philosophy has been paired with the emergence of a so-called ‘third way governance’ in the organisation of public services. This intersection has resulted in greater use of networks, inclusion of a range of different stakeholders and partnerships between civic, public and private actors (Ferlie & Andresani, 2006). In Sweden, the Act on System of Choice in the Public Sector (SFS 2008:962) that was implemented on 1 January 2009 is a concrete example of the implementation of these approaches by Swedish legislation in that the Act focuses on service user choices among various contract suppliers. This system provides choices to the service user: the individual is entitled to choose the health and social services supplier, and a contracting authority has already approved and concluded contracts
with all such suppliers. Notably, the Act does not apply to welfare services for children and young people (SFS 2008:962, 1§). In the official government report that preceded the Act, the inquiry chair noted the potential ramifications for certain groups of citizens when describing the remit as proposing a free choice system that “increases choice and influence for older people and persons with disabilities,” (SOU 2008:15, p. 27).

Active participation of the service user is a hallmark of service quality improvement approaches which, according to Ferlie et al. (1996), are also regarded as part of NPM philosophy. Ideally, active service users challenge traditional professional discretionary power by defining service quality from a consumer perspective. According to Deming (2000), this quality approach gives the public a voice in the delivery of services. The involvement of the service user and the user’s interaction with professionals is critical for service quality, since customers often form their opinion about the service primarily based on their contact with the people they actually meet. The service thus learns from customer needs and wishes, and customer feedback thus helps to constantly improve the design of the service (Deming, 2000). A consequence of this approach is that service user activity is emphasized in regulations related to service quality development in Swedish health and social care. This is exemplified by the two regulations concerning quality management systems that were issued by the Swedish National Board of Health and Welfare in 2005 and 2006. Good quality health and social care services include the participation of the service user, respect the self-determination of the individual and integrate the awareness that participation will create realistic expectations in terms of service provision. Furthermore, good quality health and social care services involve collaboration between various welfare actors; within this collaborative context, the professionals have knowledge about each other’s abilities (Swedish National Board of Health and Welfare, 2005a, 2006). Hence, the front-line professional is expected to be active and to actively collaborate with a wide range of actors i.e. with people who use the services, with other professionals, with policy makers and with groups within the community (Meads & Ashcroft, 2005).

To summarize, there is a movement towards active citizenship in citizens’ contacts with the welfare state that is promoted by complex processes
involving various societal processes and actors. The service user is expected to be active when meeting with health and social care professionals. In addition, welfare state governmental policies reflect the expectations that professionals will actively collaborate with and involve the service user and other professionals and coordinating services. In this thesis, active citizenship and its interface with health and social care services are explored through various collaboration concepts such as service user participation, empowerment and collaboration with and between multiple front-line professionals.

This thesis addresses the following questions, among others: How are these collaboration concepts, or so-called ‘buzz words’, constructed and enacted by the people that actually interact with each other in everyday practice? What conceptions do the citizens have regarding their roles as service users and what conceptions do professionals have in terms of the concept of service user participation? How is the responsibility of the individual perceived by these parties? How is interprofessional collaboration experienced and discursively constructed?

**Aim of the thesis**

The overall aim of the thesis is to explore how professionals and service users experience collaboration in health and social care.

The dissertation comprises four different subsidiary studies, the specific purposes of which are:

To explore how members of multiprofessional health care teams talk about their team (Paper I).

To identify and describe difficulties perceived by health professionals in interprofessional teamwork (Paper II).

To explore and describe the variations of service users’ conceptions of service user participation, specifically in interprofessional practice (Paper III).
To explore and describe the variations of front-line professionals’ conceptions of service user participation, specifically in interprofessional practice (Paper IV).

Organisation of the thesis

The thesis is organised into seven chapters. Chapter 1 contains the introduction and the aims of the thesis. Chapter 2 provides an overview of concepts employed in the thesis, and Chapter 3 provides an overview of earlier research, and author’s own research positions. Chapter 4 begins with an overview of the research design, participants and data sources in Papers I–IV. It then presents more details regarding the participants, procedures and analyses for each paper. The author’s own contact with the field is described, as are the ethical considerations for the studies. Chapter 5 is based on the findings reported in Papers I–IV. Chapter 6 discusses the main findings regarding collaborative processes in clinical microsystems, the implications for health and social care practice, and the implications for active social citizenship (drawing on perspectives of the consumer society and liberal understanding of social citizenship). In addition, methodological considerations are discussed, as is the relevance of the clinical microsystem approach as described in this thesis. Finally, Chapter 7 contains concluding remarks together with suggestions for further research. Part II consists of Papers I—IV.

2. Conceptual framework

The overall direction of the present PhD project concerns collaboration within the area of health and social care. This chapter provides an overview of concepts employed within the current research area.

Collaboration within health and social care services can be conceptualised and explored with a multitude of perspectives and there are several concepts associated with collaboration (Henneman et al., 1995; Langton et al., 2003; D’Amour et al., 2005; Willumsen, 2008). The main concepts that occur related to the complex social phenomenon of collaboration in this chapter are those of ‘service user participation’, ‘empowerment’, ‘interprofessional collaboration’, ‘interprofessional team’, and ‘microsystems’.

Collaboration, which in this thesis is used as an umbrella term, refers basically to ‘working together’ which, in turn, concerns relationships, activities and conscious interactions associated with both differences and commonality in the relationship between the actors (Meads & Ashcroft, 2005). The collaboration framework implies that the service user ideally is included as a partner in service delivery, something that so far has not been fully recognized in interprofessional practice (D'Amour & Oandasan, 2005). The power sharing attributes that are attached to the concept (Henneman et al., 1995) represent one of the attractions in favour of collaboration and can thus be regarded as an alternative approach to the constant topical issues of power and influence within health and social care services. The transactional process that occurs when people are collaborating is furthermore regarded as contributing to the transformation of the participants themselves by which individuals as well as communities can be empowered (Meads & Ashcroft, 2005). However, there is a threatening dimension interwoven in the concept, as collaboration is also associated with partnership with persons in opposite groups (Henneman et al., 1995) where groups with contradicting interests are united around a mutual task, for example collaboration between employers and employees.
Service user participation and empowerment

Like the other concepts that are associated with collaboration, the two concepts of service user participation and empowerment are multifaceted and there is a lack of common consensus about their meaning. The two concepts relate to each other in that people may need to be empowered in order to participate or to become empowered by enhancement of their participation, i.e. “empowering through participation” (Adams, 2008, p. 77). The associations between the concepts are applicable in the opposite situation as well; for a service user to be symbolic and only intermittently consulted by professionals is disempowering (Adams, 2008). In this line of reasoning empowerment is both a goal in itself and a means - a process to enable service user participation. However, despite the considerable overlap in meaning and the fact that empowerment concerns participation in a significant way they are not synonymous. According to Askeheim (2007) empowerment is linked with emancipation and social inclusion with a much wider democratic connotation compared to service user participation. The two concepts are further elaborated under respective sub-headings below.

In this thesis, the term ‘service user’ is applied to describe people who access welfare services (Dominelli, 2005) whereas preferably ‘professionals’ or ‘front-line practitioners’ refer to people employed to provide such services (Braye & Preston-Shoot, 1995). At the same time the complicated and socially constructed nature of the use of such terms is recognised. Besides ‘service user’, other examples of terms referring to people who access the various health and social care sites included in this PhD project are ‘patient’ or ‘resident’. In this thesis, expressions such as ‘access’ or ‘provide’ are also problematic as health and social care services are apprehended as co-created in the interface between the service user and the various professionals (cf. D'Amour & Oandasan, 2005). According to McLaughlin (2009), the use of various user terms represents diverse valuations of the individual where terms as ‘customer’ and ‘consumer’ are related to managerialization/marketization models of welfare. Besides, an alteration of a denomination may conceal that the service itself has not changed. ‘Service user’ is the term most common at present within the
discipline of social work even if it may become replaced in the near future (McLaughlin, 2009; 2010) and is thus employed in this thesis.

The professionals affiliated to an institution can be regarded as having means to act on the basis of a concentrated authority compared with service users’ often more dispersed power situations. Thus, there is a fundamental structural imbalance of power between professionals and service users (Adams, 2008). Service users as a group can consequently, according to Carr (2004), be considered as being excluded from participation in health and social care organizations. The terms ‘service user’ and ‘professional’ contain in themselves powers of expectation and reward for acting in character, and it is important to acknowledge the operations of power within personal relationships, social relations, and societal structures (Braye & Preston-Shoot, 1995).

When a unique person with her own life experiences encounters the frontline practitioners representing the health and social care organisation, that person is transformed to a client in a social process that includes both categorization by others and by the person her or himself (Lipsky, 1980). The rules and criteria for clienthood were explored in an ethnographic study of the co-constructions of identity in institutional dialogues at a crisis centre in Finland. The interactions between the service user and the professionals (here the social worker) were expected to be asymmetrical, i.e. “one party is supposed to seek and accept help whereas the other party is entitled to give it” (Juhila, 2003, p. 93). In other words, the role of the service user and the role of the professionals in the institutional setting are built on constructions where the professional is apprehended as the expert and the service user as the receiver.

‘Welfare’ in this context is defined as “the individual resources by means of which members of a society can control and consciously steer the direction of their own lives” (Ds 2002:32, p. 17). Welfare services, together with the supply systems, are resources for citizens in order to influence the level and distribution of welfare in the broadest sense. Welfare services, such as health and social care, are important for most people’s lives as collective resources.
for human welfare. Central dimensions are availability and quality, i.e. whether the services meet the needs of the citizens (SOU 2001:79).

**Service user participation**

As stated earlier, the concept of service user participation is associated with the dimension of active social citizenship, which encompasses citizens’ obligations as well as rights to be active in contacts with health and social care services. In this thesis the concept of active citizenship is directed towards citizenship as rights turned into practice, i.e. the right to be a citizen, but also the right to act as a citizen (cf. Lister, 1998, 2003). Citizenship is thus understood both as a status with a set of rights as well as a practice involving political participation in a broadly defined sense. Citizenship in terms of rights is a prerequisite for the realisation of human agency that enables people to act as agents and to express that agency. Human agency contains both personal autonomy aspects and social dimensions as the area of citizenship remains the object of political struggle for reinterpretation (Lister, 2003). According to Willumsen (2006) the citizenship concept relates to collaboration and participation on two different levels. Firstly, the formal level of collaboration, such as laws and policies which contribute to being a citizen, i.e. citizenship in terms of rights. Secondly, the interactional level of collaboration between the parties, which contributes to the persons’ opportunities of being an active participant and being able to act as a citizen.

Carr (2007) highlights the existence of a conceptual clash between ‘citizenship models’ and ‘consumerism models’ of participation, where the latter relates to individual consumerism and marketisation of welfare. This clash becomes more explicit as the ideal of participation becomes more widespread in society (Carr, 2007). Beresford (1993) also acknowledges the differences but also the overlapping features between a consumerism model that primarily meets the needs of the services, and, on the other hand, a democratic or empowerment approach that primarily meets the needs of the service users.
A literature review of the concept of user participation by Lee and Siok (2003) reports that the concept of participation is closely related to the concepts of the service users’ rights, competency, and personal growth, as well the service quality of the service provided. Other related concepts are involvement, autonomy, self-determination, shared decision-making and partnership. In this thesis, the term ‘involvement’ is treated as a synonym for participation and is employed, for example, by Beresford (1993). Furthermore, Lee and Siok (2003) describe service user participation as a mentality or a behaviour of a person, and define the concept as “an active involvement of a client (user) in the process of receiving services” (Lee & Siok, 2003, p. 336).

A definition provided by The Swedish National Board of Health and Welfare distinguishes between influencing and participation, where participation refers to “participation in everyday issues concerning various service activities” (Swedish National Board of Health and Welfare, 2003. p. 16). The working definition for this PhD project is informed by this suggested definition of participation.

**Empowerment**

The empowerment concept has, according to Adams (2008), replaced the concept of “self-help” which in Western countries has a background in the 19th century charity ideal of individualism, as well as more recent anti-oppressive equality movements. The concept is also linked to social science theory traditions such as psychoanalysis, marxism, and also to anti-oppressive pedagogy originating from Freire (Rønning, 2007).

According to Braye and Preston-Shoot (1995) empowerment theory is based on two key changes in terms of professionals’ and service users’ access and use of power, i.e. “changes in the way professionals negotiate and use their power, and changes in users’ access to their own sources of power” (Braye & Preston-Shoot, 1995, p. 118). The notion of power, which is embedded in the empowerment concept, is thereby connected to theories of both behavioural actor-oriented aspects of power as well as structural/
organisational and discursive hegemony aspects of power according to distinctions formulated by Rønning (2007). However, empowerment is not a legal term but a generic concept that can be linked to every aspect of social work and other parts of welfare work where the intervention is directed towards liberation and facilitating instead of ‘rescuing’, while the empowerment concept can also be apprehended as a rhetorical device of the welfare state (Adams, 2008).

The criticism of empowerment endeavours in health and social care organisations includes that in spite of good intentions, the practice can nevertheless be considered as being paternalistic where the professional as an expert manoeuvres the service user toward a goal that the professional considers the best, and where empowerment processes are managed within predetermined frameworks. (Rønning, 2007). Meeuwisse (1999) notices the rationalistic and idealistic basis of empowerment practice when trying to strengthen the position of marginalised groups with relatively simple actions, as the achievement of real empowerment demands exhaustive changes on multiple levels of society. Nevertheless, she concludes that the empowerment concept may be applicable when exploring service user influence in various organisations. Payne (1997) warns against implementation of empowerment based on conservative political ideology that aims to put the responsibility on the individual for satisfying needs while limiting the responsibility of the welfare state.

Concept analyses of the empowerment concept suggest empowerment is a process of helping or enabling people to take or to choose to take control and decide over factors about their lives (Gibson, 1991; Rodwell, 1996). Furthermore the helping partnership that values all those involved is emphasized (Rodwell, 1996). With the ultimate goal of achieving transformation of the service user’s situation it is the responsibility of the professionals to enable people to empower themselves by giving them “the means to consider options, explore alternatives, take choices, make decisions, reflect critically on experience and evaluate outcomes for themselves” (Adams et al., 2005, p. 14). The empowering process includes the facilitating approach exercised by the practitioners, but it also includes empowering processes among the professional groups acting in the health
and social care services. Within a contemporary social work discourse, empowerment is apprehended as having the potential to liberate both service users and workers by a holistic, inclusive, and a non-hierarchical approach (Beresford, 1993).

The concept of empowerment employed in this thesis takes its starting point from the definitions provided by Adams (2008), i.e.:

> the capacity of individuals, groups and/or communities to take control of their circumstances, exercise power and achieve their own goals, and the process by which, individually and collectively, they are able to help themselves and others to maximize the quality of their lives. (Adams, 2008, p. xvi)

The working definition of empowerment in this thesis is thus three-fold, as empowerment is regarded as a capacity, a process and also as a philosophy. Firstly, it is a capacity for empowerment that can also be described as a goal or a result. Secondly, it is a process that enables collaboration, participation and the ability to act (cf. Lister 2003; Willumsen, 2006). Finally, empowerment is seen as a philosophy with a democratic and ethical ideal about equality, valuing people as equals and having their own strengths (Renblad, 2003).

However, it must be noted that this definition cannot comprise all dimensions of empowerment, since empowerment must be considered within the local context. For example, a person can experience her or himself as being empowered in one situation but not in another context (Adams, 2008). It is also not possible to imply that service users’ needs and interests are identical or never in opposition (Whittington, 2003a).

**The interprofessional dimension of collaboration**

According to Braye and Preston-Shoot (1995) the understanding of interprofessional collaboration is vital for the empowering of both service users and professionals. Furthermore, partnership and teamwork are essential for empowering work when organisations work across professional boundaries (Adams, 2008). In this section the interest is therefore directed
towards the interprofessional dimension of collaboration. The section describes interprofessional collaboration based on the sociology of professions theory, teamwork, and collaborative learning.

Prominent features of interprofessional collaboration are the sharing of responsibilities, information, and professional perspectives (D'Amour et al., 2005). Bronstein (2003) identifies the following core components of collaboration between professionals as: interdependence, flexibility, reflection on process, innovative professional activities, and collective ownership of goals.

Nevertheless, from a standpoint of the sociology of professions, the professions are constantly striving to control society’s opinion of the professional jurisdiction, i.e. the association between a profession and its work, which is decisive for professional relationships (Abbott, 1988), and thus for interprofessional collaboration. Professional interests and professional logic are described as the aspirations to strengthen the position on the labour market and the links between the different professions’ ambitions for professional status (Torstendahl, 1990). In the workplace arena the institutionalised professional practices are maintained by professionals’ talk in which “stories that professionals tell about each other set up expectations and maintain disciplinary boundaries” (Taylor & White, 2000, p. 136). These narrations contribute to the construction of the own professional identity and are also affected by the specific legal mandate possessed by each professional group. This means that professional identities and boundaries as well as interprofessional identities do not exist per se but are social phenomena that are performed, constructed, learned, and reproduced in talk and in interaction with the specific institutional context.

The interplay between various professional logics is often described and studied in terms of barriers to collaboration (e.g. Barnes et al., 2000; Hall, 2005; Hudson, 2002; Irvine et al., 2002; Jones, 2006; Larkin & Callaghan, 2005; San Martin-Rodrigues et al., 2005). The difficulties created by professional logics and interest in institutional contexts can mean that collaboration is considered unrealistic and much too demanding, a so-called pessimistic model according to Hudson (2002). However, by acknowledging
problems and barriers a more varied approach may be applied, and Hudson (2002) recommends that professional values ought to be promoted in order to build a foundation for partnership and collaboration. Concurrently, the collaborative processes also contain potential for a mutual awareness of interdependency and can thus empower participants based on each member’s knowledge and experience (D’Amour et al., 2005).

The phenomenon of interprofessional collaboration can be defined in several ways, and there is conceptual confusion in the field (Leathard, 2003; Thylefors et al., 2005; Willumsen, 2008; Zwarenstein et al., 2009). In this thesis, interprofessional collaboration is defined as “interaction between the professionals involved, albeit from different backgrounds, but who have the same joint goals in working together” (Leathard, 2003 p. 5). D’Amour and Oandasan (2005) have introduced the concept of ‘interprofessionality’. According to the authors, interprofessionality requires a paradigm shift towards the development of cohesive practice with continuous interaction and knowledge sharing, while seeking to optimise the service users’s participation.

Collaboration between professionals is often described with a number of prefixes such as ‘multi-‘ or ‘inter-‘ and then followed by the suffix ‘professional’ or ‘discipline’. The prefix ‘inter’ in the term ‘interprofessional’ refers to the extent of collaboration, with dimensions such as professional autonomy, interdependency, proximity, interaction, and accountability. The degree of integration between professionals is understood as a continuum with the endpoints of ‘multi’ and ‘trans’ through ‘inter’, which is positioned in the middle, where ‘multi’ indicates the lowest degree and ‘trans’ the highest degree of integration between the collaborating professions (Hall & Weaver, 2001). For example, ‘multiprofessional collaboration’ indicates that individuals from the various professions coordinate their efforts and organise their work sequentially, while ‘transprofessional’ signals a crossing of professional boundaries (Payne, 2000). In this thesis, those prefixes are applied when appropriate, but the term ‘interprofessional collaboration’ is designated as the overarching term according to Øvretveit (1997) and Rawson (1994). In addition,
Thylefors et al. (2005) advocate use of the umbrella term ‘cross’ [Swedish: tvär], which in a Swedish context may be more familiar.

Furthermore, in this thesis the term ‘profession’ is separated from ‘discipline’. In order to provide further clarity, the suffix ‘profession’ designates that the empirical context of the included studies (Papers I-IV) is the environment of practice, i.e. the workplace arena instead of the academic arena. The workplace is understood as a social institution where professional knowledge is constructed and identities are played out (Sarangi & Robert, 1999). The notion of ‘discipline’ is linked to a theoretical framework where a discipline with a strong theoretical framework in turn gives access to professional jurisdiction (D'Amour & Oandasan, 2005). With that, the term ‘discipline’ is not applied in the thesis even though literature and other studies that employ that term have been included in literature searches as part of the PhD project because the concept still occur. The distinction between interprofessionality and interdisciplinarity can be summarised as interprofessionality being a response to the realities of fragmented practice while “interdisciplinarity is a response to the fragmented knowledge of numerous disciplines” (D'Amour & Oandasan, 2005, p. 9). A Cochrane review concerning interprofessional collaboration by Zwarenstein et al. (2009) points out that the occurrence of the term ‘interdisciplinary’ in empirical studies of practice leads to confusion, and as a consequence complicates the examination of the field of interprofessional collaboration.

Furthermore, this thesis does not differentiate between groups in terms of criteria applied in theories in sociology of professions such as autonomy, societal prestige, and knowledge base (Sarfatti Larsson, 1979). By the wider application of the concept ‘profession’ all kinds of occupational groups active in the studied contexts were included.

However, regardless of the use of prefixes or suffixes, all terms have the drawback that they place an emphasis on the collaboration between professionals. The definition of interprofessional collaboration in itself tends to exclude the perspective of service users and carers (Whittington, 2003b). An alternative is hence in both research and practice to employ more inclusive concepts such as ‘collaborative practice’ as has been suggested by
Whittington (2003b). Another approach is to relate collaboration to the framework of clinical microsystems, which is described further in the following section in this chapter. However, before that, there follows an overview based on more traditional forms of interprofessional collaboration in teams.

**Interprofessional collaboration in teams**

The mental image of numerous professionals working together in a team often symbolizes the whole concept of interprofessional collaboration. Nevertheless, Øvretveit (1997) points out that there are many forms of interprofessional working, and states for example ad hoc groups, work groups, and audit groups.

Teamwork can be viewed from various theoretical perspectives. From an organizational theory and efficiency management perspective, teamwork can be regarded in terms of decision-making, goal attainment, and interpersonal dynamics (e.g. Belbin, 2004; Katzenbach & Smith, 1993). Moreover, a team can be understood through group development models where the team is perceived as being developed in more or less fixed sequential stages (e.g. Lacoursiere, 1980; Tuckman, 1965). Drinka and Clark (2000) and Farrell et al. (2001) have integrated an interprofessional perspective to models of group development.

A further dimension of the understanding of teams is to consider the process of development and goal orientation as a negotiation between the group members, the nearby environment, and external stakeholders as described by Bouwen and Fry (1996). The team identity is socially constructed and reframed through interactive negotiation processes regarding the activity space of the team. According to Bouwen and Fry (1996) life in groups is embedded in conversation and the team can be understood as a social meaning system that develops over time. This perception of the team can be associated with the analyses of group self-presentations by Goffman (1959) where the members create relations with each other in order to present and perform a congruent collective interpretation of the situation both in front of
and together with the audience. In other words, the team members are collectively constructing the team and membership identity and create meaning by teamwork itself in a continuous process over time. The membership activities of constructing a comprehensive team identity also imply a reduction of possible ways to talk about the team. The reduction in the number of alternative interpretations and what it is possible to talk about in the team leads in turn to differences being ignored, i.e. discursive group formation as described by Winther Jørgensen and Phillips (2002).

Just like the social phenomenon of collaboration, the phenomenon of interprofessional teamwork is regarded as a way to manage power and influence, in this case between team members with different professional affinities. The organisation of workplaces in teams is thus seen as a way to “encode professional knowledge in the structures of organization themselves” (Abbott, 1988 p. 325). The interprofessional team can thereby be considered as a discursive instrument to handle the division of labour among professions that in turn trigger both assertive and resistance processes on the basis of professional interests, for example in the presence of medical dominance (Irvine et al., 2002; Nugus et al, 2010).

The definition of teamwork applied in this PhD project takes as its starting point that teams are socially constructed, their members develop various forms of talk and negotiation in interaction with the environment. In this way, interprofessional collaboration in teams is understood in terms of linguistic positioning processes and interactions producing the participants’ interpretations of the world (Hammersley, 1989). Consequently, a working definition for interprofessional teamwork is applied that emphasizes processes between team members, but not does not accentuate managerial efficiency targets, which opens up possibilities for various interactions between the team members:

Teamwork is the process whereby a group of people, with a common goal, work together, often, but not necessarily, to increase the efficiency of the task in hand (Freeth et al. 2005. p. xvi).
Collaborative competence and learning

The following section describes certain theories which are of importance for competence and learning in relation to collaboration. The notion of learning applied here involves changes in the individual’s capacity to experience the world as “learning is learning to experience” (Marton & Booth, 1997, p. 210).

Learning is usually described as circle-shaped processes, and Kolb (1984) notes the conceptual similarities between experience-based learning, problem-solving, and creative processes. Collaborative learning in teams in working life can ideally be seen as a circular ‘action-cum-learning process’ with the dimensions of experiences – reflection – planning – action (Ellström et al., 2000). If the experiences of the individuals become objects for a common reflection in the team this might lead to collective learning which is transformed into new actions which in their turn lead to new experiences and reflections within the group etc. The members of the team learn, in other words, through both collaborative actions and common reflections on the event. Common reflections and learning may moreover be related to the concepts of ‘reflecting practitioners’ and the reflective conversation with others as described by Schön (1991), and also to the so-called ‘communities of practice’ (Wenger, 1998; Wenger et al., 2002) where the community member's genuine interest in common knowledge development within a certain area forms the basis for collaborative learning. By that, the above-mentioned notion of learning by Marton and Booth (1997) is further extended by acknowledging learning processes through interactions in social contexts.

According to D’Amour and Oandasan (2005) collaborative competence means the individual’s knowledge of others and their own roles, good communication skills and collaborative attitudes. Crucial collaborative competence for interprofessional teamwork is knowledge of the competence of one’s own profession, and having insight and respect for the knowledge bases of other professions (Engel, 1994; Drinka & Clark, 2000; Minore & Boone, 2002).
An individual can develop his or her interprofessional competence both as a student and at work. The basis of this thesis is that participation in interprofessional teamwork in itself provides experience-based lifelong learning for the professional (Drinka & Clark, 2000). Interprofessional learning arises “from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings” (Freeth et al., 2005. pp xv). However, these notions of learning do not include the service user in the learning processes. That is why in this context emphasis is put on the knowledge process that builds on communication and learning between service user and professionals, which has been referred to above considering different empowerment processes applied in practice. Thus, these knowledge processes refer to communicative dialogues between service users and professionals as well as to the development of subject-subject relations through a shift of perspectives (cf. Jenner, 2004). Furthermore, this PhD project acknowledges that empowering transactional processes that involve both professionals and services users means learning potentials going both ways.

**Microsystem approaches to collaboration**

The starting point for this section is that collaborative work is affected by both interactional processes on micro level, organisational and systemic factors, as well as societal factors. Thus, it is recognised that collaboration takes place in the context of a larger organisation and not only within the frameworks of the team structure (D’Amour & Oandasan, 2005; San Martin-Rodrigues et al., 2005).

During an extensive Canadian research program, a conceptual framework for collaborative user-centred practice was formulated (D’Amour & Oandasan, 2005). Two related circular areas are described in that framework: 1) interprofessional education with the learner at the centre of the circle, and 2) collaborative practice with the service user at the centre. Each area contains, in turn, a number of elements built around the learner and the service user respectively, and depicts the relations between factors on micro, meso and
macro levels. Furthermore, one of the literature reviews conducted by D’Amour et al. (2005), as a part of the research program, indicated that there was a lack of studies of interprofessional practice with organisational perspectives.

Another framework of significance for the issue of organisational perspectives on collaboration is the clinical microsystem framework described by Batalden et al. (2007). The framework was formulated within the theoretical frame of quality improvement, primarily based on the work of Deming (1988, 2000), and was developed in a North American health care context. The clinical microsystem framework is founded on an organisational system perspective which understands smaller units as usually embedded in larger organisations, with the focus on a small group of people working together (Nelson et al. 2002, Nelson et al. 2007). In the present PhD project these small units are alternately referred to as ‘service’ or as ‘clinical’ microsystems, both of which refer to the organisational setting.

As defined by Batalden et al. (2007) the macrosystem represents the whole of the organisation, while a mesosystem refers to major divisions of the organisation. The microsystem represents “…the frontline places where patients and families and careteams meet. They are the small functional units in which staff actually provide clinical care” (Batalden, 2007, p. 74). They are also the basis for service user satisfaction and staff morale. The clinical microsystem is looked upon as a system which evolves over time, consisting of a small group of service users, families, and front-line professionals with administrative support and information technology, which work together towards a common goal (Nelson et al., 2007). According to Nelson et al. (2002) there have been few efforts to understand and change the small front-line units who generate the actual service.

In addition, system and ecological perspectives based on the work of Bronfenbrenner (1979, 1995, 2005) offer approaches with both similarities and differences to the above mentioned organisational system frameworks. The main similarities are that the developmental relations between active individuals and their complex environment are highlighted by both ecological models and organisational microsystem frameworks. With an
emphasis on both adaptiveness and change, and by assuming a fundamental social order with system and ecological approaches, front-line practitioners can see their interpersonal work in a wider social context (Payne, 1997). This view is also facilitated by the understanding that individuals exist within various complex systems in a broad societal structure (Baldwin & Walker, 2005). Ecological perspectives can furthermore contribute to multilevel assessment including both family system and larger scale systems enabling interventions across various system levels. The search for a so-called ‘goodness of fit’ between the person and the environment, such as social networks, can contribute to the empowerment of the person through better securing of resources (Greene, 2008). Greene (2008) also identifies links between ecological and social constructionism approaches, as human development is seen as a product of social interactions.

One example of the ecological framework applied in practice is the single shared assessment model in a British context, as described by Baldwin and Walker (2005). This model is based on the principles of the active involvement of service users and carers as well as the gathering of information at a single assessment occasion. The ecological approach which recognises the web of interacting factors also results in a demand for interprofessional coordination in order to be able to “capture and address the complexity of individuals’ life and allow those involved in the assessment to address issues from a wide range of perspectives” (Baldwin & Walker, 2005, p. 41).

There are, however, some differences between the various frameworks to be discerned. Where the ecological framework can be interpreted from the perspective of the individual's development and in relation to various societal systems, the frameworks presented by D’Amour et al. (2005) and Batalden et al. (2007) mostly describe the individual's relation to different organisational systems. The latter frameworks take their starting points from organisational theory where micro and macro levels are depicted as a number of surrounding circles which refer to levels of analysis of organisations. Here, the micro level refers to the workgroup or work unit system (Ford et al., 1988). This perspective can be compared to the ecological model where a microsystem also refers to a face-to face level, but
instead focuses on the interactions between the developing person and persons such as significant others, objects and symbols in the immediate environment (Bronfenbrenner, 1995). The mesosystem refers to the interrelations between two or more settings (Bronfenbrenner, 1979, 2005) which in this case can be transferred to linkages between primary microsystems such as home and a face-to-face setting at a health and social care agency.

A criticism of the system and ecological perspectives is that these claim to be universal and are thereby over-inclusive, and also, maintenance is overemphasised which in turn might cause conflict aspects to be disregarded. Further criticism is directed towards the presumptions of interdependence where the affecting of one part of the system will affect other parts, which disregards the fact that some systems can be autonomous in practice (Payne, 1997). In organisational theory, however, system theory is combined with contingency theory, which means that relativism and the unique environment is emphasised, thereby rejecting the claims of universalism (Ford et al., 1988). It is also possible that the interdependent dimension on micro and macro levels is more relevant in organisational contexts such as various health and social care organisations, compared with a person's relation to different multi-faceted, disparate systems in the surroundings.
3. Earlier research

This chapter provides an overview of earlier research within the studied areas of participation, empowerment, and interprofessional collaboration together with accounts of the author’s own research interest and positions in the PhD project.

Earlier research and models of participation and empowerment

During the present PhD project, literature searches were made with a search strategy inspired by Polit and Beck (2004) with the keywords ‘user’ and ‘client’ together with ‘participation’ and ‘involvement’ in the databases SocINDEX for the years 1996 to 2010, the Social Sciences Citation Index ISI, CINAHL, and Pubmed 1996 to 2008 also including the keyword ‘consumer’. The intention was to obtain an overview related to the author’s own research area by identifying in which target areas the concept has been studied. The literature search shows that empirical studies regarding service user participation are performed with a variety of focuses and objectives. It is also noted that there is no apparent general theory approach applied in the empirical studies. Possibly, the exit-voice-loyalty theory for member-customer influence by Hirschman (1970) and the theory of deliberative democracy formulated by Habermas (1998) are more prevalent; an observation which is are in line with a literature review performed by Hultqvist (2008). Furthermore, the studies seldom apply an interprofessional perspective, even in those cases where the included workplaces probably includes collaboration between multiple professions. The relation between the service user and professionals are instead often explored from the perspective of a specific profession or a specific service where an interprofessional dimension is hardly ever stressed or problematized.
Braye and Preston-Shoot (1995) state that participation takes place both at individual provision levels and overall planning levels. Beresford and Croft (1993) identify the following three different key levels for citizen involvement interventions: “a) in people’s personal dealings with agencies and services, b) in running and managing agencies and services, and c) in planning and developing new policies, organisations and services” (Beresford & Croft, 1993, p. 212). According to the distinction inspired by Beresford and Croft (1993) the literature search of published empirical studies of various forms of the exercise of social citizenship concerning service user participation indicates that the studies can be categorized into one of the following five targeted areas (Table 1).

Table 1. Overview of target areas for empirical studies of service user participation within health and social care.

| 1. | Participation in face-to-face individual service, including attitudes and interactions between service users and professionals. |
| 2. | Participation in the management of the services, including the preparation of policies and evaluations of service user centred practice. |
| 3. | Participation in society, including participation in neighbourhood local community activities. |
| 4. | Tools and measurements of participation. |
| 5. | Participation in education and research, including various forms of interactive research approaches. |

Empirical studies within target area 1, ‘service user participation in the face-to-face individual service’, relates to individuals’ personal dealings with services in the interactions between professionals and service users, i.e. aspects that concern the individual’s personal, everyday situation and his or her relationship to front-line practitioners. The personal dealings with
services on a face-to-face level include potentials to develop not just the quality of present but also future services.

Studies referring to target areas 2, 3 and 4, i.e. ‘participation in the management of the services’; ‘participation in society’ and ‘tools and measurements of participation’ relate to the key levels of running and managing agencies and to planning and developing new policies, organisations and services. It can be concluded that these levels refer to more indirect collective macro level aspects of citizenship and service user participation compared to studies in target area 1. The person acts as a voter or as a representative on behalf of a larger group of service users, for example, being a member of an advisory board. According to Jarl (Ds 2001:34) municipal decision-making processes are related to the term ‘service user influence’ [Swedish: brukarinflytande]. Accordingly, the study area of this present PhD project is participation and involvement rather than the issues of service user influence in collective and governmental decision processes.

Finally, studies in target area 5, i.e. ‘participation in education and research’, relate to all of the key areas as interactive research may involve the personal face-to-face service as well as more indirect areas. Accordingly, persons that participate in the education of students can relate to their own personal experiences of services or act as a representative of a larger group, but also provide incentives for the students to develop new organisations and services in the future when being employed.

A Swedish research review on service user participation by Hultqvist (2008) reports that the focus of the studies differs according to the various welfare areas. Research within the health area is often directed towards individuals’ personal preferences for taking part as well as the right not to participate, e.g. in shared decision-making. Also, studies concerning services directed at older adults are mainly concerned with everyday participation. In studies within other welfare areas the research questions more often concern how to accomplish participation generally for service users as a collective group. Furthermore, Hultqvist (2008) notes that the findings indicate that the
discretion of the front-line practitioners is of importance for the older adults’ influence.

Research findings in studies directed towards target area 1, i.e. ‘Participation in the direct individual service’ (Table 1), indicate that service users as well as professionals in various health and social care settings express positive attitudes towards the principle of service user participation (e.g. Lee & Charm, 2002; Butow et al., 2007; Bryant et al., 2008; Harnett 2010; Willumsen & Severinsson 2005). Furthermore, service users’ preferences for participation in areas such as decision-making are not uniform, ranging from passive to more active roles and varying according to the individual’s age and social status (Florin et al., 2006). Gender differences are also identified in interview studies among service users in Swedish childcare and care for older adults that identify preferences among women for affecting their care, and that the females also succeeded in their attempts to a higher extent compared with men who participated in the study (Möller, 1996). An interview study with service users in social services in five Swedish municipalities concludes that, in spite of a strong emphasis on client democracy in the Social Services Act, a large number of service users were unaware of important matters affecting their own cases. Furthermore, service users were not always aware of their rights or how to strengthen their position to influence outcomes. The findings also signalled that youths, immigrants, and elderly service users had larger impediments to making use of client democracy possibilities (Hermodsson, 1998).

The research findings also show tensions regarding service user participation, e.g. the professionals are expected to possess an ethos to involve the service user as an expert; however the mission to encourage service user to get involved can be regarded as realistic only if the individual has the capacity and motivation to participate (Hernandez et al., 2010). A study of Australian mental health professionals’ attitudes indicates that women and less experienced or less established staff are more likely to support user participation than other groups (McCann et al., 2008). Together with the support for the principle of the service users influencing their services expressed by policy managers and front-line workers, an interview and observation study at nursing homes in Swedish elder care by Harnett
(2010) shows how individuals’ influencing attempts are trivialized by professionals. As a part of a literature review of participation in Swedish nursing contexts, Sahlsten et al. (2008) concludes that experiences of service users and professionals differ as the former conceive participation as a personal active attitude and something they have, while participation for the professionals means something they give as they activate the person. Discrepancies between service users and professions on the notions of service user participation have furthermore been discerned in an interview study with service users and professionals in Swedish care of older adults by Damberg (2010), indicating that the participation concept has different meanings for the older adults and the professionals. The service users connected participation with obtaining necessary help, while for the professionals the concept had a meaning associated with social pedagogic rehabilitation and was redefined as an activity of the service user, i.e. taking part in care in order to preserve functions (Damberg, 2010).

Adams (2008) links the terms ‘involvement’ and ‘participation’, where ‘involvement’ relates to the continuum of taking part while ‘participation’ implies taking part more actively. Participation is in other words an aspect that exists to a greater or lesser degree and may thus be ranged. Descriptions of participation using the ideas of ladders and hierarchies are a recurrent theme in empiric studies on both macro and micro levels. For example the citizen participation model by Arnstein (1969) contains a continuum ranging from non-participation to various degrees of citizen power at the top of the ladder with the steps: manipulation, therapy, informing, consultation, placations, partnership, delegation of power, and citizen control. However, the Arnstein model has been criticised by Tritter and McCallum (2006) for being static and for disregarding relevant forms of expertise. Nevertheless, one of the contributions in spite of the above mentioned criticisms is the identification of tokenism dimensions in participation, as tokenism, according to Beresford (1993), is participation used for delay, diversion, and marketing exercises. Similar continuum models have been described by, for example, C. Evans and Fisher (1999) with the levels of information provision, consultation, participation, veto, and control, which echo Arnstein’s levels. The model by Humerfelt (2005) has further developed the Arnstein ladder by describing how the control and power relations between
the service user and professionals shift along the continuum of low – high levels of service user participation. By the user participation model described by Webb (2008) the degrees of participation in social care agencies can be analysed and measured through a social network analysis.

A framework where participation has a prominent place is the International Classification of Functioning, Disability, and Health (ICF) endorsed by the World Health Organisation’s member states. The two domains of participation and activity are closely linked to each other and are based on the persons’ engagement in his or her life situation. The ICF instrument is mainly adapted to health and disability areas, and accounts also for the social aspects of disability (WHO, 2001).

Starrin (2007) depicts an empowering model to be employed by practitioners in relation to a paternalistic-oriented model where the first model contains elements of connective, encouraging, and confirmatory talk as opposed to distanced and separating talk in the latter model. The described empowerment-oriented model infers a power sharing view, i.e. that no party loses or gains power at someone else’s expense. Similarly, an empowering model in work with older adults is set against a care model that is characterised by depersonalized ageist language and the assumptions of the older person as inevitably dependent and frail. An empowering model, on the other hand, identifies the practitioner as a skilled facilitator supporting older adults in taking responsibility for their learning, while at the same time not abandoning professional duties (Thompson & Thompson, 2001). Other examples of empowering-oriented approaches employed in practice are collaborative and appreciative enquiry models developed at family-centred services (Madsen, 2009), for young marginalized persons (McAdam & Mirza, 2009) and for maintaining older adults well-being (Reed et al., 2008). These models contains stages of discovering experiences, dreaming of ideals, and designing and delivering change which are developed in close collaboration with professionals.
Earlier research about service users and the interprofessional context

As interprofessional collaboration includes an awareness of the perspective and contributions of other professionals (D'Amour et al., 2005) such an ideal also entails a demand for corresponding awareness of the perspective and contribution of the service user. When the service user is recognised as having complementary knowledge as a so-called ‘expert-by-experience’ (Preston-Shoot et al., 2007) the above reported processes triggered by professional logics are expanded to include more dimensions. As one of the factors that can affect jurisdiction is client choices between various contesting professionals, the possibility of client power also restraints professional power (Abbott, 1988). Accordingly, a review of service user participation in a British context indicates that service user participation confronts traditional client-worker power relationships both on micro and macro levels, leading to conflicts and to professionals being challenged (Carr, 2004). However, the role of the articulated empowered service user as a focal point in the collaborative endeavour is often unrealistic, e.g. for anxious or confused persons. The service user can, in that respect, not be expected to have recourse to managing the collaborative situation without the presence of user-centred services or without being treated as a partner from the perspective of the professionals (Meads & Ashcroft, 2005).

Considering the existing knowledge concerning the relations between the person encountering services where professionals working interprofessionally there appear to be certain knowledge gaps. There is an overall scarcity of research exploring service users’ perspectives of interprofessional care (S. Shaw, 2008). According to S. Shaw (2008), studies of service user perspectives mostly focus on aspects of service user satisfaction conducted by questionnaires instead of obtaining a deeper understanding of the persons’ experiences. A literature review by D’Amour et al. (2005) of concepts for interprofessional collaboration notes that the participation of the service user is seldom explicitly stated, but finds that there is innovative intervention methods and minimized professional paternalism. The authors also comment that service users may remain
unaware of the interprofessional practice.

Findings from a grounded theory study by S. Shaw (2008) involving both service users and professionals at an urban health family centre demonstrate that some of the most valued characteristics of interprofessional work articulated by service users are affability, ability, and availability. The service users participating in the study appreciated the maintained coordination among the professionals but also appreciated the different opinions and specific expertise provided by different team members. One reservation about the otherwise appreciated communication between professional groups concerns the risks about the person’s privacy (S. Shaw 2008). The findings reported by S. Shaw (2008) of a rather small sample in one setting contribute to an increased knowledge of the service user perspective of interprofessional provided care. However, the study does not specifically address the issue of service user participation in such a context.

Interview studies by Willumsen and Severinsson (2005) with parents (who were regarded as service users in the studies) taking part in core group interprofessional meetings in residential child care in Norway suggested that the collaboration is perceived as linked to making the professionals listen, and to discussing what actions might be the best for their child. Furthermore, collaboration with the various professionals in core group meetings is considered by the service users as a way to obtain a complete understanding on the young person’s situation (Willumsen & Severinsson, 2005).

In addition there are empirical studies to be found from the perspective of the professionals, mainly in terms of barriers to service user participation. A study employing a consensus method on statements concerning user involvement in British cancer contexts discusses whether the notion of service users as ‘vulnerable’ are interpreted by the various professionals’ as a part of the power dynamics between professions and are used to justify the limitation of service users’ involvement (Daykin et al., 2004). Other barriers to service user participation in an interprofessional context can be explained by different available professional models in which emphasis on service user activity is more or less prominent, or in which user autonomy and participation are perceived to be handled differently between professions.
(Colombo et al., 2003; Lidskog et al., 2007). The interprofessional dimension in these reported studies concerns various gaps between different professionals.

Nikander (2003) analysed micro-level institutional client categorisation processes in Finnish elderly care at interprofessional meetings without the service user being present. The analysis of the situated categorization of different kinds of clienthood shows interprofessional negotiations about the rights and responsibilities of the service user and family versus those of the professionals and the institutional care. Nikander (2003) points out the need to allow for increasing heterogeneity of clienthood in elderly care, and to further understand how clienthood is constructed in both institutional meetings where the service user is absent and in face-to-face service user-professional interactions.

An area of research in which service user participation is explored at the individual face-to-face level is the extensive research concerning institutional conversations, for example Swedish studies about assessment for home care and discharge planning conferences (e.g. Efraimsson et al., 2006; Janlöv, 2006; Olaison, 2009), rehabilitation conferences (e.g. Karlsson, 2007) and vocational rehabilitation meetings (e.g. Bülow and Ekberg, 2009). A recurring theme is how power positions between participant parties are constructed and negotiated by communicative positions. However, the interprofessional dimension is seldom taken into account. When the meetings involve members of several professional groups those participants are described, although the specific interprofessional aspect in the multiparty meeting is seldom explicitly noticed. The focus is directed towards the interface between the service user, carers, and the professionals, where the latter are treated as one party or as representatives for different agencies in regard to service users and carers.

A Swedish discourse analysis of interprofessional team meetings in child and adult rehabilitation demonstrated how the service users were directed by the professionals through more or less paternalistic discursive strategies (Karlsson, 2007). According to the analysis, the liberal democracy ideal of self-determination places demands on the capacity of the individual to make
informed choices in order to avoid paternalistic actions on the professionals’ part. The responsibility to evade paternalism is hence placed on the individual service users and thus there is a risk of concealment of problems and unequal power structures. The study by Karlsson (2007) has contributed much to the increased understanding of the complexity between self-determination versus paternalism, and has placed the problem in a team meeting situation; however, it did not specifically discuss the interprofessional dimension.

Earlier research on interprofessional collaboration in teams

Based on evidence of interprofessional practice in the context of health care, systematic reviews suggest it results in a positive impact on care processes and outcomes, e.g. decreased prescribing of drugs in nursing homes, as well as enhanced professional satisfaction (D'Amour & Oandasan, 2005, Zwarenstein et al., 2006, 2009).

As mentioned earlier; teamwork can be understood from various perspectives, i.e. as efficiency units, development phases or as various negotiations of team identities. Literature searches were made during the present PhD project in the databases SocINDEX for the years 1996 to 2010, and in CINAHL and Pubmed from 1996 to 2007. The searches were for empirical team work research, using the keywords ‘inter’ and ‘multi’ together with ‘professional’ and ‘disciplinary’. The results indicated that the studies have primarily been performed by adopting perspectives where the team in question has been positioned against an ideal efficiency position. For example, there are many instruments for the study of team efficiency (e.g. Bales et al., 1979; Bronstein, 2002; West & Poulton, 1997); but also studies of attitudes and readiness for collaboration in interprofessional contexts (e.g. Curran et al., 2008; Hofseth Almås, 2007; Kolomer et al., 2010; Ødegard & Strype, 2009).

Zwarenstein et al. (2009) conclude that the focus for future research on interprofessional collaboration ought to be on the conceptualisation and measurement of collaboration. D’Amour et al. (2005) also conclude from
their literature review that many frameworks address team structures such as team composition, but fewer address collaborative processes. There is thus a need for knowledge development within the area and further research is required about processes regarding linguistic constructions, conceptions and the identity of the interprofessional team. Questions can be posed about discursive practices, membership and communities, how people talk about their membership and how collaboration is being categorised in interactive processes (cf. Little et al., 2003; Widdicombe, 1998; Winther Jorgensen & Phillips, 2002).

Research interest and positionings in the thesis

The research interest in this thesis is directed towards how service users and professionals understand, construct, and experience collaboration, both in the relationship between service users and professionals, and also in the relation between professionals and other professionals. A basic assumption in the present PhD project is that there are power imbalances and aspects of exclusion in the service users’ relation to health and social care services and to the professionals that represent those services. In that respect, service user participation and empowerment are considered as constantly present general dimensions in every single contact between service users and professionals. The area of service user participation and empowerment in regard to collaboration is consequently of decisive importance for the individual, for professionals, and for the welfare state, and is therefore of vital interest to explore. The studies in the present PhD project are part of a conceptual framework based on the notion of social citizenship which means a drive towards enabling citizens to pursue their life plans, but also acknowledging the individual’s right not to be active and to participate when having contact with the welfare state. It can furthermore be added that user-centred empowering processes promoted by the front-line practitioners, i.e. “the transfer of a capacity to exercise power, from one group to another” (Adams 2008, p. 62), in this thesis also include the notion of learning processes going two ways, involving both professionals and service users.
In this thesis the concepts of empowerment and service user participation are positioned as socially constructed with a complex mix of statements from government, and service agencies, and initiatives from service users, carers, and professionals. Moreover, the concepts are regarded as perspective-dependent and thus able to be perceived differently according to each person’s own relation to health and social care. The concepts are accordingly included in the group of so-called watchwords that different actors strive to interpret to their own advantage, i.e. a part of “…the discursive power struggle regarding the users of welfare services” (Rønning, 2007, p. 33). The premises are therefore that there are qualitative variations in people’s conceptions of the meanings they ascribe to phenomena in a phenomenographic sense (Marton & Booth, 1997).

Moreover, the above reported findings from other empirical studies suggest that although service users and front-line workers express support for both service user participation and interprofessionally provided services as means for communication and coordination of services, the endeavour appears problematic. This thesis does not disregard the impact of various professional logics, nor that interprofessional work can be related to difficulties. Moreover, it accepts that the team organisation mode may not be appropriate in all situations.

In the present PhD project the empirical interest is directed toward collaborative processes, with a focus on everyday collaboration within health and social care organisations, which means a demarcation regarding interagency collaboration. In addition, collaborative work is understood as being affected by interactional processer on both micro, meso and macro organisational levels as well as on a societal level. The standpoint taken in the PhD project is that interactive processes in clinical Microsystems are embedded in and interact with surrounding contexts and are affected by policies and regulations stipulating collaboration. Furthermore, the service user, the family, and the interprofessional team are considered as parts of the same system regarding health and social care organisations. The interest in this PhD project is hence directed towards the parts of the health and social care system where the service user and the various professionals meet face-to-face on a daily basis. D’Amour et al. (2005) argue that teamwork is the
human context in which collaboration takes place. In this PhD project this understanding is also transferred to the context of the clinical microsystem. The clinical microsystem framework offers, in other words, a possibility to constitute the main study unit of collaboration in this PhD project, which thus concentrates on the areas of the service user, the interprofessional team and collaborative processes.

The literature searches made during the present PhD project indicate that research on collaboration in health and social care regarding service user participation is often conducted from the perspectives of costumer theories and deliberative democracy and that the interprofessional dimension is seldom explored. Regarding research on collaboration between professionals, the literature reviews have noted that many frameworks address team structures and efficiency dimensions, while fewer address collaborative processes and linguistic constructions which are aspects of collaboration in need of further knowledge development. The premise for any social phenomenon, such as collaboration, employed here is that humans act and interact according to whatever meaning they give to words and acts at the time. Meanings are thus social products formed in and through defining activities and interpretative processes (Blumer, 1969; Charon, 2001). Hence, peoples' language use and understanding of various collaboration concepts is regarded as fundamental for collaboration, and by that influence the research interest in this thesis. Consequently, the above-presented research interest and positioning in the PhD project direct upcoming empirical studies toward social constructionism research.

In sum, the issue of how service users and professionals experience the multifaceted concepts of collaboration and service user participation in interprofessional contexts at the interactive micro level should be further explored.
4. Methodology

The chapter begins with an overview of research design, participants, and data sources of the four papers comprising the thesis, and describes their interconnections. Subsequently, there follows a presentation of the participants, the research strategy, the procedure and an analysis of each paper. Finally the author’s prior understanding and own contact with the field are accounted for, followed by a discussion of ethical considerations.

Overview

This thesis is based on empirical data from four studies (Papers I – IV) that in various ways explored collaboration in health and social care, i.e. how service users and professionals experience collaboration in institutional settings. The direction resulted in an overall research design based on qualitative inductive inquiry approaches, including attentiveness to the perceptions of the local actors as described by I. Shaw and Gould (2001).

The data material consisted of two main data sets, the first for Papers I - II and the second for Papers III - IV. The data material comprised transcribed individual interviews and focus group interviews, audio tapes and, as part of background data, field notes and questionnaires.

Even though Lincoln and Denzin (2005) suggest that it is no longer possible to categorise practitioners of research paradigms and perspectives in a simplistic and singular way, it may however be claimed that the theoretical position in this thesis is connected to an overall social constructionism paradigm assuming “human reality as socially constructed reality” (Berger & Luckmann, 1967, p. 210). The starting points of the PhD project was that humans produce social reality through interactive processes (Hammersley, 1989; I. Shaw & Gould, 2001), that social reality is a collective social
product (Wetherell, 2001) and that the phenomena studied can have diverse qualities in individual experience (Gubrium & Holstein, 2001).

Hence, the thesis has drawn on social constructionism with additions of pedagogical and interactive approaches, to address the overall research aim. Although the thesis had an interdisciplinary approach the studies were grounded in theories within social work and other areas of the social sciences, thereby acknowledging social work research as a “field of investigation that examines human interactions around human well-being (or its lack)” (Dominelli, 2005, p. 229).

**Overview of research design**

In order to address the complex social phenomenon of collaboration in health and social care a diversity of research strategies was considered necessary. According to Denzin and Lincoln (2005) the strategy of inquiry ought to connect with the theoretical perspective as well as to methods for collecting empirical materials. The research strategies employed in the studies (Papers I-IV) as well as data generation and analysis approaches can be considered as consistent with the above mentioned social constructionism paradigm.

An overview of the employed research strategies, data sources and data analysis approaches in each paper is presented below (Table 2). Research strategy, participants, procedure, and analysis are further described under each subheading in this chapter, where Papers III and IV are presented together.
Table 2. Overview: research strategies, data sources and data analysis approaches, Papers I-IV

<table>
<thead>
<tr>
<th>Paper</th>
<th>Research strategy</th>
<th>Data source</th>
<th>Data analysis approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Discursive social psychology</td>
<td>Focus group interviews (n=6) with professionals</td>
<td>Discourse analysis, discursive social psychology</td>
</tr>
<tr>
<td>II</td>
<td>Critical incident technique</td>
<td>Individual interviews (n=18) with professionals</td>
<td>Latent content analysis</td>
</tr>
<tr>
<td>III</td>
<td>Phenomenography Interactive research</td>
<td>Individual interviews (n=22) with service users</td>
<td>Phenomenography 2nd stage: follow-up dialogues</td>
</tr>
<tr>
<td>IV</td>
<td>Phenomenography Interactive research</td>
<td>Individual interviews (n=15) with professionals</td>
<td>Phenomenography 2nd stage: interactive reflection seminars</td>
</tr>
</tbody>
</table>

The selected strategies were considered to have provided the following information in each of Papers I-IV regarding the aim of the thesis:

**Paper I:** discursive social psychology, with references primarily to Potter and Wetherell (1987) provided information about participants’ interactive linguistic positioning and discursive constructions of the interprofessional team “per se” and the functions of the discerned discursive patterns.

**Paper II:** critical incident technique, with reference to Flanagan (1954) provided information about participants’ individual experiences of difficult events in interprofessional teamwork. Accounts of how these identified events were talked about and acted upon by the participants themselves and others allowed data for further interpretations of interprofessional learning based on the perspectives of sociology of professions (Torstendahl, 1990) and learning (Ellström et al., 2000).
Papers III-IV: phenomenography, with reference to Marton (1981) and Marton and Booth (1997) provided information about participants’ perceptions of the phenomenon of service user participation in interprofessional contexts, both in their roles as service users (Paper III) and as professionals (Paper IV). It also allowed data for structuring the variation of these perceptions into descriptive categories. The phenomenographic approach allowed discussions on how these descriptive categories varied in complexity. Furthermore, the research strategy allowed data in a proceeding step for analysis of variations between perceptions in the participant group of service users reported in Paper III and the participant groups of professionals reported in Paper IV. In addition an interactive collaborative research approach, with reference to Svensson and Aagard Nielsen (2006) allowed information for a widened analysis of the findings, and also offered mutual learning opportunities for the researcher as well as the participants.

Background data was provided by the front-line practitioner participants after the individual interviews (Papers II and IV), and included their understandings of the team’s interprofessional approach according to a questionnaire developed by Thylefors et al. (2005). All participants completed the questionnaire. The returned questionnaires were compiled and processed in the computer program Excel, and basic calculations of frequency distributions (mean and variation) were made. Furthermore, in order to obtain a contextual understanding, when entering the study sites for Papers III and IV, observations of interactive situations between service users and professionals were conducted as “observer-as-participant observations” (Gold, 2001) and field notes were made.

The research interest was directed, as mentioned earlier, towards how service users and persons from various professions experience collaboration. The assumption can be made that the various studies (Papers I-IV) offered the persons participating in the PhD project a variety of opportunities to conceptualise and construct the meaning of the social phenomena of collaboration in health and social care settings. These interactive processes were assumed to take place in the following settings:

a) In front of and with the interviewers and participants in focused group interviews (Paper I);
b) In front of and with the interviewer in individual interviews (Papers II, III and IV);
d) At interactive follow-up dialogues and reflection seminars in connection with conversations about preliminary findings (Papers III and IV).

In this PhD project, interview accounts were thus not primarily regarded as a procedure of data collection but rather as a procedure of data generation, and were understood as social interactions and as accounting work by the participants in the generation of a version of social reality (Baker, 2004).

Finally, it can be noted that with the described research strategies, data sources, and data analysis approaches employed in the PhD project, the main knowledge claims are made regarding concept development of various subject matters concerning collaboration, i.e. service user participation and interprofessional teamwork. Thereby, the intention was to go beyond a descriptive analysis and also to approach the possibility of developing conceptual models regarding collaborative health and social care. However, the applied methodological approaches and sampling strategies did not provide findings that were transferable to an overall population of service users or professionals. Therefore, the findings must be related to the contexts in which data were generated, aspects that are further elaborated in chapter 6, subheading Methodological considerations.

**Overview of data sites and participants**

The data sites for the studies that are part of the thesis were nine different interprofessional clinical microsystems in health and social care services in two county councils and one municipality located in the southern area of Sweden. The activity areas for the included clinical microsystems varied from care for older adults, primary care, rehabilitation care, mental health and hospital care. Thus, the empirical contexts explored in this thesis were predominantly health care contexts. One data site was located at a municipality managed elder care facility, and teams at other data sites in turn were operating over county council - municipality borders managed by the county council. Each clinical microsystem required the services of a
multitude of professionals who worked in interprofessional teams. The encounters between service users and professionals took part over a relatively long period of time. Furthermore, service user control structures such as collective user-controlled service provision or direct payment systems were not present in the settings.

The overall sampling strategy was purposive sampling (Silverman, 2010) in order to include participants with a variety of experiences concerned with the aim of the studies. In this PhD project the main sampling decisions were made in regard to three areas: teams, clinical micro systems and participant individuals. As stated in chapter 3, the clinical microsystem was considered as the main study unit of collaboration in this PhD project because of the potential to concentrate on the areas of service user, the interprofessional team, and the collaborative processes, i.e. the research aim. One challenge to the use of the concept of clinical microsystem as a data site for the studies was that the spatial demarcations of the “frontline places where patients and families and careteams meet” (Batalden 2007, p. 74) were quite indistinct in practice and were dependent on local characteristics. The sampling strategy was therefore to focus primarily on interprofessional teams for sampling strategies and then consider team members, the service users in contact with the team, and the closest organisational surrounding as ‘the clinical microsystem’. In this PhD project the concept of the clinical microsystem was limited to either a work unit or a program directed towards a specified service user group. Finally the selection of potential participants was made.

The participants involved in the PhD project were recruited from two kinds of group; 1) front-line practitioners working in the included interprofessional teams within the clinical microsystems; and 2) service users having contact with three of the nine teams. An overview of number of participants, professions, and teams is presented below (Table 3). In all, 87 persons participated in the four studies (Papers I-IV). Twenty-two out of those 87 persons participated in their roles as service users. The service user groups were: persons with chronic pain disorders, obesity conditions, or persons staying at short-term placement at elder care facilities (Paper III). Sixty-five professionals from a total of ten professions
participated in the studies (Papers I, II and IV). The professions were: administrative assistant, dietician, social worker, occupational therapist, physical therapist, physician, nurse assistant/assistant physical therapist, psychologist, registered nurse, and speech therapist. Social workers participated in all three studies that involved professionals (Papers I, II and IV); however without forming a majority of the participants due to the personnel structures of the included clinical Microsystems with quantitative predominance of various health care professionals.

More extensive descriptions of the participants are reported within respective subheadings later in this chapter, except for Papers III and IV that are presented together.

Table 3. Overview of number of participants, professions and teams, Papers I – IV

<table>
<thead>
<tr>
<th>Paper</th>
<th>Number of participants</th>
<th>Number of women and men</th>
<th>Number of service users</th>
<th>Number of professionals</th>
<th>Number of professions</th>
<th>Number of teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>32</td>
<td>25/7</td>
<td>-</td>
<td>32</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>II</td>
<td>18</td>
<td>14/4</td>
<td>-</td>
<td>18</td>
<td>9</td>
<td>4¹</td>
</tr>
<tr>
<td>III</td>
<td>22</td>
<td>14/8</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>IV</td>
<td>15</td>
<td>12/3</td>
<td>-</td>
<td>15</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>65/22</td>
<td>22</td>
<td>65</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>

1. Source: Paper I. Of which five participants also participated in the study presented in Paper I.

**Interconnections between studies**

The interconnectedness between the four studies (Papers I-IV) is displayed in the figure below (Figure 1). All of the studies focused on the topic of collaboration and were connected with the next by starting from the self presentations of the interprofessional team members with the aim of obtaining the perspective of the professionals (Paper I), then widening the
focus to difficulty dimensions and interprofessional learning aspects of teamwork (Paper II). The next step included the service user perspective, and thereby expanded the study scope from the interprofessional team ‘of the professionals’ towards the interprofessional clinical microsystem ‘of the service users’ (Paper III) and the professionals’ perceptions of service user participation (Paper IV).

<table>
<thead>
<tr>
<th>Paper</th>
<th>Interconnections between papers</th>
<th>Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Self presentations of the inter-professional team</td>
<td>Professionals</td>
</tr>
<tr>
<td>II</td>
<td>Widening to difficulty dimensions in teamwork</td>
<td>Professionals</td>
</tr>
<tr>
<td>III</td>
<td>Expanding from the team ‘of the professionals’ to the clinical microsystem ‘of the service user’. Focusing on service user participation.</td>
<td>Service users</td>
</tr>
<tr>
<td>IV</td>
<td>Professionals’ perceptions of service user participation</td>
<td>Professionals</td>
</tr>
</tbody>
</table>

Figure 1. Overview describing the interconnections between Papers I-IV, including participant perspective in each study.

The progress of the PhD project and interconnections between the studies can furthermore be related to the research phases described by the research program Bridging the Gaps, of which this PhD project has been an integrated
part. Studies employed within the framework of Bridging the Gaps are suggested to involve the research phases of documenting, identifying, and formulating design principles (Jönköping County Council, 2007). In this PhD project those phases were adapted to documenting and identifying in all papers (Papers I - IV). The formulating phase involved formulating the findings into models in order to conceptualise and thereby contribute to improving collaboration in health and social care.

**Paper I**

Paper I explored how members of multiprofessional health care teams talked about their team. Specifically, team members’ talk was analysed to explore the discursive patterns that emerged and their function. Below follows a description of participants, sampling strategy, research strategy, procedure, and analysis.

**Participants**

All of the teams managed by one county council in the southern part of Sweden were invited to apply for participation in focus group interviews by identifying and characterising themselves as a ‘multi-professional team’. The applied sampling strategy was thus a so called “member-identified category sampling” (Hammersley & Atkinson, 2000). The invitation was issued via the agency staff newspaper and intranet. A total of 24 teams applied, foremost by team members themselves and twelve were selected. Teams comprising fewer than three professions were excluded, along with teams that were assessed as being too similar or too close geographically. By applying convenience sampling (Patton, 2002) six focus groups were recorded on tape, and those six tapes were used in the analysis, which thereby reduced the numbers of teams in the final sample from twelve to six. The six interviews still covered the activity areas included in the original sample. The activity areas for the included teams were primary care, rehabilitation care, mental health, and hospital care.
The participant group comprised thirty-two persons whose professions included: administrative assistant, occupational therapist, physical therapist, physician, psychologist, nurse assistant, registered nurse, social worker, and speech therapist. Twenty-five were women and seven were men.

**Discourse analysis**

Discourse analysis was employed to explore linguistic constructions and discursive patterns in transcripts of focus group interviews. A focus group interview refers to a guided group discussion with the intention to “generate a rich understanding of participants’ experiences and beliefs” (Morgan, 1998, p. 11). Focus group interviews were considered appropriate in connection with discourse analysis, since the social interactions that take place in such interviews make it possible to analyse expressions of discursive practices (Winther Jørgensen & Phillips, 2002).

There are several approaches to discourse analysis but some common themes are the social constructionist understanding that discourse is of central importance in enacting social phenomena; another theme is investigation of how meanings and/or actions are constructed by attending to interactional contexts and texts focusing on how versions of social realities are achieved in and through talk and text (Nikander, 2008). The research method applied in Paper I was based on the perspective of discursive social psychology described by Potter and Wetherell (1987). Discursive social psychology is an analysis of coherent speech (talk and text) in a certain social context, where individuals use the language as a resource to construct versions of their social world. More specifically, the analysis explores how accounts and utterances are used as flexible resources and examines the functions they have (Potter & Wetherell, 1987).

**Procedure and analysis**

The group interviews were conducted in 2000 within the context of a previous development project run by a county council. The aim of that
project was to study interprofessional teamwork with regard to the following: collaboration, learning, professional roles, and relations with clients (Kvarnström & Wallin, 2000). The themes of the project were reflected in the interview schedule. Semi-structured interviews were held in personnel rooms at the workplaces and each team was interviewed once for 1.5–2 hours. The audio-taped interviews were transcribed verbatim. Of the four papers included in this thesis, Paper I is the only study where the responsibility for data generation was held by other persons besides the author.

The data were analysed as suggested by Potter and Wetherell (1987) to explore how language was used as flexible rhetorical resources and what functions they have. The analysis focused on the participants’ discursive constructions of interprofessional teamwork, the way participants talked about their group and especially their use of pronouns. A starting point for the analysis was that language contains the basic categories we use to understand ourselves and to define who we are as members of a group (Widdicombe, 1998). The pronoun I and you-discourse is a basic component of human thought and the sense-making identification of oneself excludes at the same time ‘the others’ (Mühlhäusler & Harré, 1990).

The coding was done manually and was directed towards the team members’ use of the personal pronouns we, they and I. All of the passages that contained one of those pronouns were noted and then reread to identify distinguished organisational features of consistency, such as shared versions, negotiations and how the participants talked to each other. At the same time, variability in the passages was identified, for example in regard to positioning and shifts in meaning.

In the second stage of the analysis the initial findings were positioned in a theoretical context of discursive membership (Winther Jørgensen & Phillips, 2002) and discourse communities (Little et al., 2003), to enable further interpretations of discursive patterns per se, and of their functions and consequences. Finally, a meta-narrative summation was made based on the self-presentations of the interprofessional team that occurred in data.
Paper II

Paper II identified and described difficulties perceived by professionals in interprofessional teamwork. Furthermore, utterances on verbal actions and resolutions were explored to enable discussions of the implications for interprofessional learning.

Participants

In Paper II the study sample consisted of 18 front-line practitioners who were members of a total of four interprofessional teams. The included teams originated from the teams participating in Paper I, but the original six teams were reduced to four. One team was no longer active and the other unit was excluded owing to high turnover. The activity areas for the included teams were primary care, rehabilitation care, mental health, and hospital care. The composition of most of the included teams had changed since the earlier study, but their principal tasks were essentially the same. Returning to the teams in order to perform individual interviews with team members provided opportunities for wider variations in the participants’ accounts compared to the group interviews performed in Paper I.

The sample of respondents was based on a stratified purposeful sampling strategy by combining maximum variation sampling and random purposeful sampling (Patton, 2002). Maximal variation was achieved by including one individual from each participating profession in every team, eighteen people all told (out of a total of 38 people). If the professional group consisted of more than one individual in the team, a random selection was made among those individuals. The inclusion criterion was at least one year’s experience as a team member. All those approached agreed to participate in the study.

The professions of the participant group were: administrative assistant, nurse assistant, occupational therapist, physical therapist, physician, psychologist, registered nurse, social worker, and speech therapist. Fourteen persons were
women and four were men. Five of the 18 participants had also participated in the study presented in Paper I. The ages of the participants varied between 33 and 60 and they had between 6 and 38 years’ experience in the profession (mean 20, SD 10). The respondents had been members of the team for 1.5 to 15 years and worked with the team for an average of 27 hours a week.

All respondents perceived their team as interprofessional or transprofessional and none identified their team as having multiprofessional characteristics in accordance with a team type index developed by Thylefors et al. (2005), which indicated relative closeness and integration among the members from different professions.

**Critical incident technique**

Critical Incident Technique (CIT) was used to identify and describe perceived difficulties in interprofessional teamwork. CIT is made up of a set of procedures for gathering facts on human behaviour in defined situations in order to facilitate their potential usefulness, for instance, in providing solutions to practical problems. The perceived difficulties that were identified during the interview were considered as incidents. To be considered critical, the incident must occur in a situation where the intent and consequences of the incident is sufficiently definite (Flanagan 1954). The application of CIT was motivated by its potential to identify perceived difficulties and to allow data for further interpretations of implications for interprofessional learning.

**Procedure and analysis**

The interviews were conducted during the winter of 2005/2006 and were carried out either in the participant’s own room at the workplace or in small conversation rooms on the premises. Interviews lasted about sixty minutes. A semi-structured interview form was used based on critical incident technique described by Flanagan (1954).
Experiences related to critical incidents in interprofessional teamwork were elicited by asking, ‘Are there any difficulties working together with several professional groups in the team?’ followed by, ‘Can you remember a situation during the past year when you experienced such a difficulty?’ Once the situation was established, follow-up questions were asked, such as in what context the incident occurred, what the consequences of the incident were for the interview subject and for others, what actions were taken by the actors involved, and whether or not the situation was resolved. The interviews were recorded on tape and transcribed verbatim.

A qualitative latent content analysis was performed to identify the significant and underlying meaning in the text passages (Downe-Wamboldt, 1992; Morse and Field, 1996). Flanagan (1954) himself does not state a specific analytic approach; however the described process of “the induction of categories from the basic data” (Flanagan, 1954, p. 344), redefinitions, and development of tentative categories etc can be considered as being in line with a qualitative content analysis.

A total of 40 distinct critical events were identified in the 18 interviews (median 2, range 1-4). The meaning unit extended to the incident and its consequences. The meaning units were first condensed to a description closely related to the text. The descriptions were abstracted and coded to interpret the underlying meaning. The codes were then sorted in inductively shaped sub-themes (Graneheim & Lundman, 2004). Three themes emerged through amalgamating the sub-themes and switching between data and relevant literature on teamwork and interprofessional collaboration. The themes thus represent constructions that overstep the bounds of descriptive analysis. In the second phase, the critical incidents were explored on the basis of the sub-themes with respect to utterances on verbal actions in joint discussions and statements as to whether a resolution could be reached in order to enable further interpretations of learning situations.
Papers III - IV

Papers III and IV explored and described the variations of service users’ (Paper III) and professionals’ (Paper IV) conceptions of the social phenomena of service user participation, specifically in interprofessional practice. The two papers were based on a similar research strategy and are hence presented together.

**Participants**

The study sample in Paper III consisted of 22 persons, 14 women, and eight men, recruited from three different service user groups with interprofessional services in order to obtain sufficient variation of conceptions. The study sample consisted of eight persons with chronic pain disorders, seven persons with obesity conditions, and seven persons staying on short-term placements at elder care facilities.

In Paper IV the study sample consisted of 15 professionals, 12 women, and three men, recruited from three different interprofessional teams active in three clinical microsystems serving the above mentioned service user groups.

Participant recruitment was conducted with a purposive sampling strategy (Silverman, 2010) to obtain heterogeneity of the participant groups. The inclusion criterion to the study reported in Paper III was that participants should be in the middle or at the end of the expected service period to ensure they had personal experience of the services. The variables were age and gender. Exclusion criteria were cognitive impairment or need of palliative care. A local contact person (staff) approached the individual meeting the criteria with information on the study, including details of the confidentiality policy and stressing that participation was voluntary. A total of 26 service users were asked to participate and 22 persons accepted. The age of the participants varied from the age group of 15-24 years to the age group of 75-84 years.
To obtain variations among professionals, one person from each participating profession in each team was included, i.e. a stratified purposeful sampling strategy as defined by Patton (2002) was used. In four cases, where the professional group consisted of more than one individual, a selection was made among those individuals based on random sampling or based on information of future team attendance. The potential respondents were approached by the researcher, either by visiting a team meeting or by telephone. Agreement to participate in the study was provided either by telephone, in person, or was communicated by a contact person at the setting. All individuals approached agreed to participate in the study. The professionals represented in the first team were: administrative assistant, occupational therapist, physical therapist, physician, psychologist, registered nurse, and social worker. In the second team the professionals were: dietician, physician, registered nurse, and social worker. Finally, in the third team the professions represented were: occupational therapist, physical therapist, nurse assistant, and registered nurse. In the first and second setting the social workers were part of the team; in the third setting the social workers were not members of the team but participated at various multiparty meetings in the clinical microsystem. The ages of the participants varied between 27 and 61, and they had between 2 and 26 years’ experience in the profession (mean 16, SD 7). The respondents had been members of the team for 1 to 18 years and worked with the team for an average of 20 hours a week. All respondents perceived their team as having interprofessional or transprofessional characteristics, which indicated relative closeness and integration among the members, according to a team type index developed by Thylefors et al. (2005).

Setting

The identified clinical microsystems were: a program for chronic pain rehabilitation, a program for surgical treatment of obesity, and a short-term municipal home for older adults. Thus, the activity areas for the included teams were rehabilitation care, hospital care, and care for older adults. In order for an individual to attend these programs and the short-term home in a role as a service user the person had to accept his or her presence and also had to go through an assessment and approval process by professionals.
settings were characterised by relatively preset programmes structuring the daily routines. Furthermore, service user control structures such as collective user-controlled service provision or direct payment systems were not present at the settings. In each clinical microsystem the professionals worked in interprofessional teams. The role of the service user in team meetings varied from the service user taking part in most of the team meetings, or being part of some multiparty team meetings, or having only individual encounters with the various professionals.

As described earlier in this chapter the sampling strategy was to focus primarily on interprofessional teams and clinical microsystems to obtain a variation of activity areas, and in the next step to obtain variations among potential participant individuals.

As opposed to member-identified sampling strategies applied in Papers I-II an appeal was made to the macrosystem development leaders in two organisations to identify settings where management and staff were interested in joining a study with the intended research approach. Inclusion criteria for the settings were: the existence of a team comprising multiple professions, the presence of social workers in the team, or alternatively, services directed towards older adults, plus an ambition to develop service user participation and a readiness to work interactively with the researcher during the PhD project.

**Phenomenographic approach**

A phenomenographic research approach was used to explore and describe the variations of the participants’ conceptions of service user participation, specifically in interprofessional practice. Phenomenography is an empirical research approach “...which is directed towards experiential description” (Marton, 1981. p. 180). The objective of the research approach is to describe and understand the nature of the variations of experiencing a certain phenomenon. Phenomenography focuses on people’s qualitatively different ways of reasoning about the phenomenon itself, i.e. the informants’ perceptions of the second order (Dahlgren & Fallsberg, 1991; Marton, 1981;
Marton & Booth, 1997). Furthermore, a person’s understanding and experiencing of certain phenomena are intertwined with the capacity to act, and individuals are seen as “the bearers of fragments of differing ways of experiencing that phenomenon” (Marton & Booth, 1997 p. 114).

In this PhD project, the phenomenographic notion of learning as a change of the capacity to experience the world (Marton & Booth, 1997) is also acknowledged as processes that are situated in social contexts (cf. Wenger, 1998).

**Interactive approach**

Collaborative research includes a wide collection of different research variants such as action research, participative research and interactive research (Ellström, 2007). A fundamental idea behind interactive research is to allow reciprocal relations between participants and researchers (Svensson & Aagard Nielsen, 2006). By emphasizing mutual knowledge creation processes (Dominelli, 2005) the intention of an interactive approach is common learning and research with the participants instead of doing research on presumably passive objects (Herr & Anderson, 2005). The interactive approach was used in the form of discussions regarding mutual aims and the content of the service user interview guide. These discussions were held with staff in the initial phase. Furthermore, the interactive approach was used in the form of interactive follow-up dialogues with former participant service users and in reflection seminars with professionals about preliminary findings.

**Procedure and analysis**

The interviews were conducted between 2008 and 2009 and were carried out either in the participant’s own room at the service agency or in small conversation rooms on the premises. The interviews lasted between sixteen and fifty-four minutes.
A semi-structured interview form was used and contained two main areas: the participant’s conceptions of the phenomenon of service user participation, specifically in interprofessional practice. In order to elicit the person’s unprocessed experiences (Marton & Booth, 1997) no explicit definition of the concept of service user participation was provided and the phenomenographic introductory question was ‘What comes to mind when you think about participation?’ (for professionals: service user participation) and then ‘How do you conceive of participation when several different professions are involved?’ The participant was requested to give examples from his or her own experience, in line with Marton and Pang (1999). Depending on the conceptions articulated, the participant was requested to further describe his or her thinking in order to verify that the interviewer understood the meaning (cf. Kvale, 1996). The interviews were recorded on tape and transcribed verbatim.

When the interview was finished the participating service users were asked by the interviewer to give consent to be contacted again for a follow-up dialogue four to six months after the first interview.

The analysis was done as three parts: first to define the preliminary descriptive categories, and next to order these categories according to complexity, and finally to perform individual follow-up dialogues and joint reflection seminars based on these preliminary findings.

The analysis of the interview data for the descriptive categories was directed towards the research aim using a phenomenographic analysis procedure performed in the steps described by Dahlgren and Fallsberg (1991) presented below:

(1) The recorded interviews were studied with the transcriptions to improve familiarity with the empirical material.
(2) The most significant dialogue sequences in each interview related to the aim of the research were identified and condensed to provide “a short but representative version of the entire dialogue” (Dahlgren & Fallsberg, 1991, p. 152). The context of the statements was also noted in order to preserve a close version of the dialogue.
(3) The marked dialogue sequences were compared to each other in order to identify variation and similarities.
(4) Similar dialogue sequences were grouped by interaction between the entirety of the empirical material and the various dialogue sequences. 
(5) The groupings were then articulated to obtain descriptive categories. Steps four and five were repeated until a satisfactory preliminary analysis could be obtained.
(6) The dialogue sequences in each preliminary descriptive category were compared to each other to identify variations and similarities within categories: for example sequences in which the interprofessional dimension was explicitly pointed out were compared with dialogue sequences of service user participation without that specific connotation.
(7) Finally, the preliminary descriptive categories were labelled and (8) contrasted, based on the similarities and variations, which were ordered according to complexity.

In the last phase of the analysis the preliminary findings from the services user interviews were discussed and reflected on in individual follow-up dialogues between the researcher and the former participant service users, and in reflection seminars with professionals. In total seven persons (three women and four men) of the 22 original interview persons (service users) participated in the follow-up dialogues (Paper III). Depending on the participant’s wishes, the meeting took place either in the person’s own home, at a café, at the workplace, or on a return visit to the service agency. The conversation was tape-recorded. Four reflection seminars were performed with former participants (professionals) and their colleagues in connection with the teams’ ordinary team meetings on the basis of the preliminary findings from interviews from both service users and professionals. The follow-up dialogues and seminars were tape-recorded.

The author’s contact with the field

The thesis is based on the author’s pre-understandings as a front-line practitioner in various professional positions within Swedish health care, elderly care, and home care. Furthermore the author has experience from
being a manager and a project leader in the areas of human resource management and organisational development, mainly within the public sector in Sweden. This experience has contributed to an overall interest in knowledge development concerning collaboration in health and social care, and to some degree of insight into the working conditions that exist in those contexts.

The contact with the settings for the study presented as Paper I was initiated while the author held a position as a project leader at a regional R&D project. This led to a research paper, which was later expanded into Paper II. The access to the settings in the latter parts of the PhD project (Papers III-IV) was obtained through contacts at the Jönköping University and through the participation of the larger Bridging the Gaps research program.

**Ethical considerations**

Permission to carry out the studies was given by the department managers at the health and social care agencies and by the regional ethical review board at Linköping, Sweden (Dnr 02-092, Dnr 181-08). In the study reported in Paper I, written consent for extensive use of existing audio tape recordings was obtained from the former participants of an earlier development project. In the following studies, written consent was obtained from the participants, after assurances were given of confidentiality and of the possibility of participant withdrawal from the study at any time without any explanation whatsoever.

According to the code of ethics regarding evaluation and research, approved and revised by the National Association of Social Workers (2008) voluntary and written informed consent shall be obtained from participants, without undue inducement to participate, with due regard for participants’ wellbeing, privacy, and dignity, and after giving information about the right to withdraw. Furthermore, while reporting research results the participants’ confidentiality shall be protected by omitting identifying information unless authorization for disclosure has been obtained. During
research it is also important to avoid conflicts of interest and dual relationships with participants.

When a person encounters the professionals representing health and social care services there are power imbalances and issues of exclusion and a categorising transformation towards clienthood may arise (Adams, 2008; Braye & Preston-Shoot, 1995; Carr, 2004; Lipsky, 1980; Mik-Meyer, 2004; Nikander, 2003), as has been described previously in chapter 2. These basic assumptions raise ethical dilemmas in research.

By identifying and categorizing single participants as being excluded, the risk of stigma is discernable which, according to Järkestig Berggren (2010), is a constant pressing issue within research with vulnerable groups. However, the estimation is that the categorization of the persons who participated in the studies reported in Paper III as being vulnerable and exposed does not cause significant harm for the persons’ wellbeing and dignity.

An ethical dilemma when conducting studies concerning collaboration is that participants may experience pressure to conform to general societal ideals that promote active citizenship, participation, and teamwork. These demands may be further enhanced in consensus processes in focus group interviews and joint reflection seminars, and may also lead to pressure not to withdraw from the study. Individual interviews with service users can contribute to an anxiety that an expressed discontent with services or an expressed unwillingness to participate will lead to problems in future encounters with the professionals. These ethical dilemmas may be viewed as a limitation of the study as the participants may have considered themselves as being dependent on further access to health and social care as service users or being dependent on maintaining good working relations with other professional colleagues, and thus may have sought to adapt to the above described societal ideals during the interviews.

Furthermore, an interactive research approach where preliminary findings are presented and discussed jointly with former participants and other colleagues entails a greater demand to protect confidentiality when reporting
samples and findings. By being open to the above described ethical concerns and risks the ambition has been to adopt an ethical pattern of behaviour with regard to participants’ wellbeing, privacy, and dignity. Protecting confidentiality has thus appeared to be of interest in the PhD project.

In the studies reported in Papers I and II, both the researcher and participants were part of the same organisation, though they did not have positions within the same mesosystem. The researcher had no operational management jurisdiction within the participants’ working areas, thus dependency between the parties ought to be low. No similar relationships between researcher and participants existed in the following studies.
5. Findings

This chapter is based on the findings reported in Papers I-IV. The findings are related to the overall aim of exploring how service users and professionals experience collaboration in health and social care.

How professionals experience interprofessional collaboration is explored by analysing their talk about their team (Paper I), and by identifying and describing perceived difficulties in teamwork in order to enable discussions of the implications for interprofessional learning (Paper II). Moreover, how collaboration is experienced in terms of the variations of conceptions of service user participation specifically in interprofessional practice, is explored and described from the perspective of the service user (Paper III), and from the perspective of the professionals (Paper IV).

The findings of each paper are discussed in the following chapter 6.

Self presentations and discursive patterns (I)

Paper I addresses how team members talk about their team in focus group interviews. The analysis focused on the participants’ discursive constructions of interprofessional teamwork, on the way they talked about their group, and, in particular, on their use of the words ‘we’, ‘they’ and ‘I’.

We and ’the others’

When the team members talked about their team a number of basic features in the use of the pronouns ‘we’ and ‘they’ were found. ‘We’ was related primarily to the team in question, whereas ‘they’ or ‘them’ were chiefly associated with service users or groups and individuals who worked more traditionally or who were not part of the team. ‘We’ sometimes included
persons who usually worked outside the team, and also service users. Service users were related both to ‘we’ and ‘them’.

The mutual linguistic construction ‘we the team’ dominated in the interviews, but the pronoun ‘we’ was used in numerous ways. There were variations in the meaning and use of ‘we’, such as when uniprofessional knowledge and work were integrated and shared with the team. ‘We’ was also used in reference to groupings of professionals, as well as to seniority and to relations between students and their supervisors. In the interviews, the respondents sometimes used the term ‘I’ to refer to themselves as a member of a profession or as a person without any notable professional links (Table 4).

Table 4. Variation in the use of the pronouns ‘we’ and ‘I’ in the team context.

<table>
<thead>
<tr>
<th>‘We’ in the team context</th>
<th>‘I’ in the team context</th>
</tr>
</thead>
<tbody>
<tr>
<td>All team members, including services users, other people, or units</td>
<td>The person’s own profession</td>
</tr>
<tr>
<td>The person’s own profession</td>
<td>Profession-specific decisions and work</td>
</tr>
<tr>
<td>The person’s own discipline, sub-speciality</td>
<td>In relation to a colleague in another organization</td>
</tr>
<tr>
<td>Colleagues</td>
<td>One person without any notable professional connection</td>
</tr>
<tr>
<td>Grouping of professions</td>
<td></td>
</tr>
<tr>
<td>Experienced senior practitioners</td>
<td></td>
</tr>
<tr>
<td>Supervisors (in relations to students)</td>
<td></td>
</tr>
</tbody>
</table>

The meta-summary of the self-presentations of the team members, in which they constructed and made sense of themselves as ‘we-the-team’ are as follows:

We work effectively and we organise our work in the best interests of and for the comfort of the patients. As a team we are good for the patient because we have a broad knowledge from other professions which has enhanced our professional skills. We trust and support our
colleagues, and they back us up in decisions. The team poses no threat, but instead, supports and empowers us. The team gives us resources to support our opinions in relations with other institutions and groups of professionals. We offer the most modern, state-of-the-art care, and we know what is best in contacts with other service providers.

**Discursive patterns of knowledge synergy and trusting support**

The discursive patterns that were explored in team members’ talk about their team are formulated as ‘knowledge synergy’ and ‘trusting support’. Knowledge synergy comprised factors of cross-learning and extension, and two-can-see-more-than-one metaphors. Also, in some cases the team members indicated that they had overlapping and blurred professional boundaries, although this was not a notable feature.

The discursive pattern ‘trusting support’ comprised factors of mutual trust, personal chemistry, and family metaphors. The team members displayed a safe and affectionate social climate, and they signalled a we-work-together-well culture. The pattern also involved being accountable to each other, having consensus in decisions, and having a shared ideology.

**Perceived difficulties in interprofessional collaboration (II)**

Paper II addresses difficulties in teamwork perceived by professionals. Furthermore, remarks on consequences, verbal actions, and resolutions in regard to the perceived difficulties are explored. The findings are related to a discussion of the implications for interprofessional learning which are further elaborated in chapter 6, Discussion.

Three themes emerged in the content analysis of perceived difficulties in connection with interprofessional teamwork: (A) team dynamic; (B) the knowledge contribution of the professions, and (C) the influence of the
surrounding organisation. The sub-themes and themes are visualised in a diagram (Figure 2). Themes A and B are placed in an inner circle that symbolises the team and the clinical microsystem. Theme C is placed between the inner circle and the outer circle, where the latter illustrates the team’s context, i.e. meso and macro systems. The lines between team and context are dashed to indicate permeability.

Figure 2. Reported difficulties experienced by team members (n= 18) in interprofessional teamwork. Themes (A-C) and sub-themes (1-9). (Paper II).

Below follows a description of the themes and subthemes.
Team dynamic

One theme (sub-themes 1-3) was related to experiences of the team dynamic that arose among team members when they acted as representatives of their professions, either as individuals or as sub-groups, in relation to one another. One of the origins of the team dynamic was that there was a perceived demand to act as a team member in all situations. The sub-themes were: *The team decides over the individual/professional group, Unequal responsibility for own and others’ tasks,* and *Others overstep professional boundaries.*

Knowledge contribution of the profession

Another theme (sub-themes 4-6) was the team members’ experiences of interactions among the knowledge bases of the various professions and skills in the team. Both the persons who believed they had been affected as individuals and persons who noticed the situation from a majority position described the consequences as being that the team’s potential could not be fully met and that the team thus could not adopt the expected holistic view on the problems of the service user. If everyone did not have the same information and thus the same current knowledge, they could not intertwine, and dealing with the patient was considered more difficult. The sub-themes were: *Contribution is not valued, not put to use, Lack of consensus* and *Uneven distribution of current knowledge.*

Influence of the surrounding organisation

A further theme (sub-themes 7-9) reflected the influence of the surrounding meso and macro levels of the organisation on the interprofessional approach. The theme correlated with the other two themes. For example, team members experienced difficulties when the organisation had hierarchical valuations of the various professions which made it more difficult for individuals to feel like valued members of the team. The sub-themes were: *Hierarchical valuations, Changes of organisation and setting,* and *Team cannot be put together with the right professions.*
Joint discussions and resolutions regarding difficulties

Table 5 shows reported difficulties (sub-themes) that were managed via joint discussions among the entire team, related to perceptions of whether or not the discussions led to resolutions. The nine sub-themes are placed in a matrix. One axis shows ‘Talk among the entire team’ versus ‘No talk among the entire team’, while the other axis shows ‘Resolved’ versus ‘Not resolved’. The matrix thus forms four fields. For example, field 1 shows difficulties that were talked about jointly in the team and which were perceived as having been resolved. Uneven distribution of current knowledge was managed through painstaking efforts on the part of those who had the information to spread knowledge reaped from various meetings throughout the team. When the team could not be put together with the right professions, the joint team strategies were described as identifying “second-best solutions” and trying to compensate for the lack of competency. The sub-theme Lack of consensus was managed both with and without joint speech and appears thus in both field 1 and 3.

Table 5. Reported difficulties (sub-themes) that were managed/not managed via joint discussions among the entire team, in relation to whether or not the difficulties were resolved. One sub-theme occurs in two fields. (Paper II).

<table>
<thead>
<tr>
<th></th>
<th>Resolved</th>
<th>Not resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Talk among the entire team</strong></td>
<td>1. Talk, resolution</td>
<td>2. Talk, no resolution</td>
</tr>
<tr>
<td></td>
<td>Uneven distribution of current knowledge</td>
<td>Unequal responsibility for own and others’ tasks</td>
</tr>
<tr>
<td></td>
<td>Team cannot be put together with the right professions (“second-best solution”)</td>
<td>Changes of organisation and setting</td>
</tr>
<tr>
<td></td>
<td>Lack of consensus, dimension of differences in judgement</td>
<td></td>
</tr>
<tr>
<td><strong>No talk among the entire team</strong></td>
<td>3. No talk, resolution</td>
<td>4. No talk, no resolution</td>
</tr>
<tr>
<td></td>
<td>Team decides over the individual/occupational group</td>
<td>Contribution not valued, not put to use (rarely speech among the entire team)</td>
</tr>
<tr>
<td></td>
<td>Others overstep professional boundaries</td>
<td>Organisation’s hierarchical values influence the team</td>
</tr>
<tr>
<td></td>
<td>Lack of consensus, dimension of lack of coordination</td>
<td></td>
</tr>
</tbody>
</table>
Service users’ perceptions of service user participation (III)

Paper III reports findings from individual interviews with service users. In the study, the variations of service users’ conceptions of service user participation, specifically in interprofessional practice, are explored and described.

An outcome space of five qualitative variations of service user’s conceptions of service user participation was identified. The variations are formulated as descriptive categories A-E:

A. Information transmission
B. Choices and decisions among resources
C. Comfortable relationship and communication
D. Interaction for increased understanding
E. Conditions for service user participation

*Information transmission*

Conceptions of service user participation in descriptive category A are related to information transmission between the professionals and the service user. The service user obtains information concerning his or her situation. In turn, the service user expresses information and wishes, and then the professionals decide what to do, given their professional expertise. The interprofessional dimension in descriptive category A touches upon the situation of receiving information from the different professionals by listening to their various instructions. The interprofessional dimension also touches upon the idea of the service user needing only one entrée to the various professionals within the clinical microsystem. The service user only has to voice needs to the first person she or he meets and then the staff members transmit and coordinate the information between them so that the message reaches the right person.
**Choices and decisions among resources**

The meaning attributed to service user participation in descriptive category B is choices and decisions among resources made available by the professionals. Service user participation involves both choosing among specific providers and also making choices on everyday matters. Examples of choices in the actual clinical microsystem are ordering a certain kind of food or deciding when to take a walk. The interprofessional dimension in descriptive category B refers to the service user’s actions in choosing to assemble the most appropriate professional groups according to his or her needs.

**Comfortable relationship and communication**

Conceptions of service user participation in descriptive category C are related to respectful and comfortable relationships with professionals. The service user is being listened to and the dialogue with the staff is conducted on an equal basis. The environment is friendly and cosy. In contrast to categories A and B, conceptions of service user participation in descriptive category C are connected more closely with relationships and a participatory environment created by the staff. The interprofessional dimension in descriptive category C touches upon personal chemistry and familiarity with the various staff members where the professionals collaborate with both the service user and with each other. Through relationships and communication, the service user’s contacts with the various professional groups are interwoven within an entirety. The conception of service user participation draws on ideas of working together with the staff and also contains family metaphors. The team members see the individual as a person and not as an objective ‘case’.

**Interaction for increased understanding**

The meaning attributed to service user participation in descriptive category D refers to the processes that occur when the individual obtains insights and
increased understanding of his or her own situation, through dialogue and contact with professionals. Those connections also involve adjustments and preparatory work for the future. The interprofessional dimension of service user participation in descriptive category D relates to the service user learning to plan his or her own strategies through interaction with the different team members.

**Conditions for service user participation**

In descriptive category E the phenomenon of service user participation is experienced as dependent on several conditions, such as personal characteristics of personality and age. Younger generations are seen as more assertive. Other individual conditions for service user participation are having knowledge about his or her own situation, and the fact that professionals are expected to inform the person about his or her rights as a service user. Furthermore, the phenomena of service user participation vary in significance due to the length of the contact and the seriousness of the situation. The interprofessional dimension in descriptive category E touches on the conditions of the individual to handle multiparty situations with different professional groups in the clinical microsystem. Such personal conditions include communication ability and shyness as well as former vocational experience from multiparty conversations.

**Professionals’ perceptions of service user participation (IV)**

Paper IV addresses the variations of conceptions of service user participation, specifically in interprofessional practice, by front-line practitioners working interprofessionally.

An outcome space of seven qualitative variations of service user’s conceptions of service user participation was identified. The variations are formulated as descriptive categories A-G:
A. Inclusion in activities and social events
B. Obtaining guidance
C. Having self-determination and choice
D. Getting confirmation from and contact with professionals
E. Negotiating for adjustment
F. Personal responsibility through insight
G. Circumstances surrounding service user participation

Descriptive categories A, C, E and G comprise a number of sub-categories.

**Inclusion in activities and social events**

Conceptions of service user participation in descriptive category A are characterised by the notion that service users are involved in their own lives and engaged in social interaction with other service users at the premises. The variation within the descriptive category encompasses the sub-categories *Participation in a general social setting, Participation in social and rehabilitative activities arranged by the professionals,* and *Service user independence from professional assistance.* Unlike other descriptive categories in the outcome space, an interprofessional dimension of service user participation is not apparent in descriptive category A.

**Obtaining guidance**

Conceptions of service user participation ascribed to descriptive category B refer to service users being given guidance by the professionals. The interprofessional dimension of obtaining guidance means that service users are, through the guidance given from multiple perspectives, afforded a greater opportunity to understand and assimilate the message by the access to multiple – but complementary – explanations.
**Having self-determination and choice**

The meaning attributed to service user participation in descriptive category C is related to service user self-determination and to choices among various service alternatives. The variation within the descriptive category covers the sub-categories of *The right of service users to decline offered service*, *Obtaining information about rights and alternatives*, and the dimension of *Choice*. The interprofessional dimension touches upon the notion that service users are responsible for taking advantage of, choosing among, and selecting the professionals who are present in the clinical microsystem. The professionals are meant to inform users about the options available with respect to services provided by the various professionals. For their part, involved service users are meant to take advantage of these opportunities.

**Getting confirmation from, and contact with professionals**

The meaning attributed to service user participation in descriptive category D is service users’ opportunities to come into contact with and get to know the professionals. Contact and confirmation mean that workers and service users meet at the same level and that service users open up to the professionals and make their needs understood. The interprofessional dimension contains aspects such as service users’ access to and communication with the various people present. The presence of several involved actors improves prospects for participation, and the wider network of contacts makes it easier for service users to tell others what they need. The interprofessional dimension is further described as contact with multiple professional groups; getting to know the various persons involved and their fields.

**Negotiating for adjustment**

The conception of service user participation in descriptive category E is that service users and the professionals express opinions that are subsequently negotiated in various ways. Goals for the service user’s stay at the service
agency are jointly set and followed up. The variation within this descriptive category encompasses the sub-categories *Adjustment of the organisation according to service user preferences*, and *User acceptance of and adjustment to organisational frameworks*. The interprofessional dimension has to do with dialogue and agreements that include service users and the present professional groups. Because the negotiations involve more persons than the one service user and a single front-line practitioner, the agreements are perceived as more sustainable. In the discussion, all participants contribute their personal perspectives, including the service user, which sets the stage for a potential distribution and equalisation of the expert role between the service user and the professionals.

**Personal responsibility through insight**

The meaning attributed to service user participation in descriptive category F is that the service users become motivated to take personal responsibility for their future lives by means of information, conversations with the professionals, and joint decisions. In descriptive category F, the focus is on individual development of insight and change. Participation is referred to as an educational endeavour where the service users reflect, learn, and develop insight and understanding through the relationship with the professionals. The interprofessional dimension concerns the professionals’ broader opportunities to reach individuals so that they can be motivated to change. Because of the various professions’ different areas of expertise, which allows them to contribute different theories and perspectives, service users gain greater opportunities to understand and gain insights into their situations and the changes that are necessary in future.

**Circumstances surrounding service user participation**

In descriptive category G, service user participation is understood as being dependent upon several circumstances such as personal characteristics and institutional conditions. The variation within the descriptive category covers
the sub-categories of *Service user’s individual circumstances* and *Institutional circumstances*. The interprofessional dimension is characterised by how the team meeting process is designed and whether service users are given the time and opportunity to be involved. The individual’s personality, background, and sense of security provide varying conditions for inclusion in interprofessional settings.
6. Discussion

In this chapter the main findings from the four studies of this thesis are discussed in regard to the overall research aim to explore how service users and professionals experience collaboration in health and social care. In this thesis the unit of the clinical microsystem was considered as the main study unit of collaboration, i.e. the place where the service user, family, and the interprofessional team members meet. Hence, this chapter is structured accordingly, first discussing the findings in terms of empowerment and collaborative processes in clinical microsystems, along with suggestions for continuous learning and reflection on practice. The implications of the findings for meso- and macrosystems are then discussed. Next, the implications of the findings for active social citizenship are discussed, drawing on perspectives of consumer society and liberal understanding of social citizenship. Finally, methodological considerations are addressed, along with the relevance of the clinical microsystem approach applied in this thesis.

The exploration of collaboration in this thesis has been directed toward the collaboration taking place within health and social care organisations. The research area has thereby mainly been directed toward the relations between professionals and service users, and towards various conceptions of collaboration in everyday practice. Thus, the knowledge contribution to the area is mainly concept development on various subject matters concerning collaboration. The research interest emanates from the basic interactionism notion that human beings’ actions – and collaboration – in regard to social phenomena are based on the meaning that the phenomena have for them (cf. Blumer, 1969). Moreover, as research within social work examines interactions around human well-being (Dominelli, 2005) the field of investigation in the PhD project has addressed human interactions when services are organised interprofessionally, i.e. how the organisation of health and social care services affects the meeting between the service user and the professionals.
Furthermore, the notion of social citizenship and the wider connections with democracy values are included in the research interest in the interactional level. That is, the encounter between service users and professionals as a means to improve the quality of welfare services by democratization of the collaborative relations between service users and professionals. This enhances the possibility for the individual to act as a citizen according to Lister (1998).

**Collaborative processes in clinical microsystems**

*Discursive patterns and perceived difficulties in interprofessional teamwork (I - II)*

In the participant team members’ (front-line practitioners) use of the pronouns ‘we’ and ‘them’ regarding the team the service users were described both as ‘we’ and ‘them’. The variation of the inclusion of the service user but also other individuals to a joint ‘we’ was an indication of a flexibility of positioning in terms of which persons belonged and did not belong to the team.

The self-presentations of ‘we as a team’ constructed when the team members talked about their team show two discursive patterns; knowledge synergy and trusting support. The function of these discursive patterns signifies various resources for the membership of an interprofessional team. One possible function of the mutual linguistic construction of the team identity that emerged as the discursive pattern of knowledge synergy is to facilitate clarification and exchange of each team member’s professional knowledge during the collaborative process. In addition, the pattern of trustful support may function to provide resources, such as mutual support among team members in favour of user-centred actions and adaptations, besides contributing to a compassionate work environment.

The members’ talk of teamwork as knowledge synergy making use of the various competences is in line with the cognitive transformation which
suggests that individuals can reach self-awareness of their own knowledge base and acknowledge the contribution of other professionals, thereby reaching a holistic interprofessional perspective (cf. D’Amour et al., 2005; Drinka & Clark, 2000; Lundgren, 2009). According to Willumsen and Hallberg (2003) the development of trust and a confident atmosphere is essential to the collaborative process. The two identified discursive patterns furthermore functioned to exclude and outperform other forms of work organisations in the institutional context (i.e. ‘the others’) as the team members perceived their decisions as more valid when based on consensus and collective knowledge.

When becoming a professional, the individual acquires and is socialised into certain types of professional discourses with identifiable linguistic features, which also give authority to the individual and the professional group (Sarangi & Roberts 1999). The patterns that emerged in the talk by the team members presented in Paper I can subsequently be interpreted as a form of interprofessional discourse which also renders authority to the members of the interprofessional team. The self-presentations thereby provided powerful rhetorical resources for the team members as well as the sharing of an extended ‘we’ with the service user and with other professional groups.

However, all teams go through a process of creating consensus and trust, which also means a reduction of possible discourses. The findings in Paper I may thereby be compared with concepts such as group think by Janis (1982), self-presentations of performing team by Goffman (1959) and discursive membership and communities with reference to Little et al. (2003), Widdicombe (1998) and Winther Jorgensen and Phillips (2002). According to Goffman (1959) team members build relationships with each other based on reciprocal dependence and familiarity in order to present a relevant definition of a certain situation. Nonetheless, the participants’ flexible use of the pronoun we to represent professional and subgroup positions, as well as various positions in regard to the service users, appeared to be a way of managing the expertise and leadership in the team. The flexible use of language may thereby also function to ease the pressure for consensus among the team members.
**Perceived difficulties**

The findings of difficulties perceived by members of interprofessional teams reported in Paper II identified three themes, two of which can refer to collaborative processes in clinical Microsystems. The third theme, *the influence of the surrounding society*, can refer to meso- and macrosystems and is therefore discussed in the next section. One of the two themes related to the microsystem that emerged in the analysis is *team dynamics* when, for example, other members overstep professional boundaries. The other microsystem-related theme is difficulties in regard to the *knowledge contribution of the profession*. Both themes can be interpreted from the starting point of theories of the sociology of professions. By applying the concept of professional jurisdiction, i.e. the links between the profession and its work (Abbott, 1988), interpretations can be made regarding the findings that an effort to control the other team members’ notion of the professions’ work is also taking place within the framework of the interprofessional team. It can thus be concluded that such aspects of professional jurisdiction, which are essential for the relations between professions, were discernable also as difficulties in interprofessional collaboration. Professional jurisdiction can furthermore lead to professional systems ‘closing down’ on one definition of a situation, or can mean that disputes occur about perspective with the risk of the professionals being stuck if they cannot consider competing views and embrace the perspectives of others, as has been described by Braye and Preston-Shoot (1995). Those processes may, in other words, be described as a form of professional jurisdictional ‘short-circuiting’. The findings in that respect echo those of a number of studies concerning interpersonal barriers in interprofessional teamwork (e.g. Barnes et al., 2000; Irvine et al., 2002). However, by linking the identified difficulties to their perceived consequences, i.e. how the participants perceived them to be handled and resolved, new patterns occurred, which had not previously been addressed in the above-mentioned studies (see table 5, chapter Findings).

Furthermore, in comparison to the above-mentioned studies of barriers to interprofessional collaboration, further dimensions are added in Paper II. The findings show that the perceived consequence of difficulties was a restriction in the collaborative resources required to arrive at a holistic view and to
adopt a server user perspective through adapting the team's resources to the needs of the service users. As well as the consequences of the individual front-line professionals there were feelings of frustration and powerlessness. However, the interpretation cannot be made that the team members thereby offered a lower standard of the service compared to other work forms, but rather that the potential of interprofessional collaboration was not being utilized. This indicates that the study participants related the difficulties to a disempowering weakening of the team’s interprofessional function and results. The difficulties described were found in the field between the ideal picture of what the interprofessional team could achieve and when it was perceived as not working in that way.

When relating the findings in Paper I with findings presented in Paper II the discursive patterns identified in Paper I can be interpreted as having potential for the team members’ handling of difficulties. For example, the discursive pattern of knowledge synergy may provide resources to handle difficulties concerning lack of consensus by facilitating a readiness to manage and overcome such situations.

_Service users’ and professionals’ conceptions of service user participation (III-IV)_

The findings presented in Paper III show that the qualitatively varied conceptions of the social phenomena of service user participation among the participant service users can be grouped and articulated as five descriptive categories: A-E. By applying the phenomenographic notion that the capabilities for experiencing particular phenomena in certain ways “…can, as a rule, be hierarchically ordered” (Marton and Booth, 1997, p. 111), the five descriptive categories are ordered according to complexity, thus ranging from conceptions of service user participation as performing fairly unprocessed acts of information transmission (descriptive category A) to more complex interactions with the various professionals involving the participant as part of his or her own context (descriptive category D). Finally, there is descriptive category E, _Conditions/circumstances for service user participation_, forming a broad-spectrum category depicted as a vertical
block with connections to the other identified conceptions of service user participation (Figure 3, left column).

<table>
<thead>
<tr>
<th>Service user’s conceptions: descriptive categories</th>
<th>Professionals’ conceptions: descriptive categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>A. Taking part in activities and social events</td>
</tr>
<tr>
<td>A. Information transmission between professionals and service user</td>
<td>B. Obtaining guidance</td>
</tr>
<tr>
<td>B. Choice and decision among resources provided by professionals</td>
<td>C. Having self-determination and choice</td>
</tr>
<tr>
<td>C. Comfortable relationship and communication with professionals</td>
<td>D. Getting confirmation from and contact with the professionals</td>
</tr>
<tr>
<td>---</td>
<td>E. Negotiating for adjustments</td>
</tr>
<tr>
<td>D. Interaction with professionals for increased understanding relating to life situation</td>
<td>F. Personal responsibility through insight</td>
</tr>
</tbody>
</table>

Figure 3. Relations between identified descriptive categories: service users’ conceptions of service user participation, left column (Paper III) in relation to professionals’ conceptions, right column (Paper IV).

In turn, when exploring and describing the variations of professionals’ conceptions of service user participation, the findings show an outcome
space comprising seven descriptive categories: A - G (Paper IV). These descriptive categories are ordered according to complexity and nature of variation regarding activity, proximity, and conscious interactivity, all aspects that, according to Meads and Ashcroft (2005), can be generally applied to collaboration. Thus, they range from meanings attributed to service user participation as actions with relatively modest demands for proximity and interactivity as service users taking part in social and activating events to more complex interactions between service users and professionals for personal responsibility through insight. Finally, as in Paper III, there is the descriptive category Conditions for service user participation forming a broad-spectrum category depicted as a vertical block with connections to the other descriptive categories in the outcome space (Figure 3, right column).

**The interprofessional dimension and implications for empowerment processes**

In the literature, some of the specific aspects of interprofessional collaboration are the sharing of professional perspectives, information, and responsibilities (D’Amour et al., 2005). The findings indicate that there are links between the participant service users’ perceptions of service user participation and the interprofessional characteristic of sharing. For example, service user participation was conceptualized by service users as having access to the various professional perspectives, both as part of information transmission and as interaction for increased understanding. In addition, as one of the factors that may affect professional jurisdiction is client choices between various contesting professionals (Abbott, 1988), the meaning attributed to service user participation in terms of choosing and compiling the appropriate professional group (descriptive category B) can affect existing responsibility-sharing structures among the various professional groups.

Moreover, the findings indicate that the variation of service users’ conceptions of service user participation presented in Paper III implies different positions of the individual in the interface with the various professionals. For example, descriptive category A, *Information*
transmission, indicates a relatively passive role which can be explained by the participants drawing on different available professional models present in the interprofessional context where emphasis on service user activity is more or less prominent, as described by Colombo et al. (2003). In turn, conceptions of service user participation in descriptive category D, *Interaction for increased understanding*, are related to learning and understanding connecting the individual to her and his own context, taking its starting point from the interaction with the various professionals. Furthermore, the findings indicate that the concept of service user participation cannot be entirely related to the issue of *Choice and decisions among available resources*. That is, collaboration in terms of service user participation cannot only be apprehended as promoting contract relationships between a consumer and a service provider (cf. McLaughlin, 2009), as contract relationships can be perceived as a part of the contemporary dominant welfare model as described by Jordan (2008). This study suggests that conceptions of service user participation in interprofessional practice also encompass dimensions with a spirit of togetherness and interactions in the clinical microsystem (descriptive category C and D).

The findings reported in Paper IV regarding professionals’ perceptions indicate that working interprofessionally is understood as being important because it provides the service user with increased opportunities in a number of ways; e.g. to understand and assimilate information, to choose among the variety of professional offered services, to equalize the professionals’ expert role, and to give greater opportunities to gain insight for a person’s own development. Thus, the interprofessional dimension discerned in the variations of how to conceive the phenomena of service user participation are mainly understood by professionals in terms of amplified opportunities for participation. In addition, these aspects place demands on the ability of the service user to help himself and to seize these opportunities.

The participation of the service user/patient is seldom explicitly stated in studies concerning interprofessional collaboration; however empirical findings exist showing decreased professional paternalism (D’Amour et al., 2005). These are aspects which correlate with the above reported findings of
the perceptions of equalized expert role between users and professionals from various professional groups.

However, one interesting aspect of the findings is that the outcome space of perceptions of service user participation by the participant front-line practitioners (Paper IV) contains dual potentials regarding empowering processes in practice. That is, the findings reported in Paper IV provide a starting point for a discussion concerning various implications for both empowering and paternalistic processes in relation to service user participation. According to Adams et al. (2005) the empowerment responsibility of professionals includes processes such as giving people means to consider options, to take choices and reflect critically on experience. Actions which can be concluded are discernable as the professional’s tasks in relation to the meanings ascribed to the phenomena of service user participation by the professionals. Empowerment processes can, in spite of good intentions, be considered as paternalistic, and empowerment processes can be managed within predetermined frameworks. (Rønning 2007). The findings suggest that in the identified variations of professionals’ perceptions of service user participation there are potentials, more or less implicit, that can be turned into the opposite of empowerment processes, i.e. paradoxes that may be referred to as ‘the dual faces of service user participation’. For example, unequal structures might be concealed in conceptions of service user participation as Negotiations for adjustment, if the matching processes between the person’s demands and the service resources in the clinical microsystem are coupled with a belief that the parties have equal power and resources, meaning that the responsibility for avoiding paternalism is placed entirely on the individual service user (cf. Karlsson, 2007). The aspects of the findings pointing out that agreement are perceived as more robust when made with several parties, can simultaneously be reversed to its downside. The opportunity for the service user to re-negotiate an agreement if she or he regrets the earlier decision can be apprehended as more difficult if several professional groups have been involved in the decision-making process, compared with a situation involving only two parties. The individual may in consequence lose self-determination and become disempowered, meaning the power balance is transferred even more to the advantage of the professionals. Thus, the
interprofessional dimension tends to enhance the potential for both empowering and paternalistic processes.

**Congruencies and gaps**

By analysing the relations between the two outcome spaces of conceptions identified in interviews with participant service users (Paper III) and professionals (Paper IV), both congruencies and gaps are discerned. Firstly, by relating the two outcome spaces to each other it can be concluded that some descriptive categories overlap each other regarding qualitative characteristics. These relations are displayed in figure 3 by positioning the overlapping descriptive categories next to each other (Figure 3). Service user participation was conceptualised by service users as *Comfortable relationship and communication* (Paper III: descriptive category C), which can be interpreted as corresponding with professionals’ perceptions of the concept as *Getting confirmation from and contact with the professionals* (Paper IV: descriptive category D). Similar interpretations can be made of parallels between other descriptive categories. For example regarding conceptions of service user participation as choices, decisions, and self-determination is identified in both papers (Paper III: descriptive category B, Paper IV: descriptive category C).

Other studies exploring service user participation in various health and social care contexts have suggested a continuum ranging from lower to higher levels of service user control implying the most desirable position is on the top of the ladder, as for instance, Arnstein’s (1969) often cited ladder of citizen participation. Another example is C. Evans’ and Fisher’s (1999) model for collaborative evaluation. Using the phenomenographic approach applied in Papers III and IV, the findings are distinguished from those studies. The outcome spaces can instead be described as the respondents’ qualitatively different ways of reasoning about the phenomenon itself (Marton, 1981). The findings are thereby consistent with a study on experiences of service user participation by seldom heard users that does not give emphasis to any particular kind of service user participation (Hernandez et al., 2010). However, by applying the model of C. Evans and Fisher (1999) to the findings reported in Papers III and IV it may be concluded that neither
the participant service users nor the front-line practitioners conceptualized participation as the service user being in control, for example, by having user-controlled service provisions. An interesting point emerging from the findings is thus that the meanings ascribed to the social phenomena of service user participation by either of the groups did not tend to accommodate such extended notions of service user power.

One example of gaps between the two participant groups is that dialogue sequences in interviews with the professionals grouped as descriptive category A, *Taking part in activities and social events* (Paper IV), was not apparent in dialogue sequences from the perspective of the participant service users (Paper III). This discerned gap is in line with findings from other studies also indicating gaps between service users’ and professionals’ concerning the dimension of activity in relation to participation (e.g. Damberg, 2010; Sahlsten, 2008). It can nevertheless be concluded that the understanding of service user participation as taking part in various service activities in some respects correlates with the International Classification of Functions (ICF) by WHO (2001) as well as definitions employed by the Swedish National Board of Health and Welfare, i.e. “participation in everyday issues concerning various service activities” (Swedish National Board of Health and Welfare, 2003. p. 16).

Moreover, the emphasis on the responsibility of the service user herself or himself in regard to perceptions of service user participation in the interviews with the professionals (Paper IV) is not as prominent in the outcome space identified in the interviews with the group of service users (Paper III). This discerned gap regarding responsibility can be explained by participant professionals directing responsibility to the other ‘party’ of the collaborative endeavour by linking to social constructions of the ‘active citizen’ and the liberal democracy ideal of self-determination, including the moral implication for the service user to take responsibility for his or her welfare (cf. Dahlstedt, 2008; Johansson & Hvinden, 2007a; Karlsson, 2007). This may in turn be interpreted both as an empowering strategy of the professionals that enhances the self-determination of the individual, and that constructs the practitioner as a skilled facilitator supporting the service user to take responsibility according to a empowerment model as described by
Thompson and Thompson (2001). Alternatively, it could be seen as a way to reduce professional responsibility for the task of facilitating service user participation.

To conclude, when amalgamating the findings of the two outcome spaces presented in Papers III and IV, a picture emerges of how the social phenomena of service user participation may be perceived by both service users and professionals in these contexts. By taking the starting point from the findings of the service user’s perspective (Paper III) with the addition of the dimension of activity derived from the professionals’ perspective (Paper IV) a condensed overview is attained regarding qualitative variations of how service user participation is experienced in interprofessional health and social care contexts. The variations are thus formulated as new descriptive categories A-F, ordered hierarchically according to complexity in regard to activity, proximity, and conscious interactions in the collaborative relation between service users and professionals:

A. Taking part in activities and social events
B. Information transmission having access to the various professional perspectives
C. Making choices, decisions, and having self-determination
D. Having communication and mutual relationships with the team members
E. Interacting with team members, drawing on their various perspectives for increased understanding and personal responsibility relating to the life situation
F. Individual and organisational conditions for service user participation.

Below, these condensed descriptive categories will be further discussed related to the framework of clinical microsystems.
Implications for health and social care practice

The understanding of interprofessional collaboration is considered a vital aspect of the empowering of service users as well as professionals. However, collaboration requires systems for communication and decision-making (Braye and Preston-Shoot, 1995). In this thesis this notion is added, acknowledging a need for systems and models for service user participation, reflection, and learning.

One implication for health and social care practice derived from the findings of this PhD project emanates from empowerment theory, i.e. that the responsibility of professionals to enable service users to empower themselves by reflecting on experience and to make informed decisions (Adams et al., 2005) also highlights the need for professionals to interact with other professionals. By drawing on their various perspectives for knowledge synergy the front-line practitioners may be able to further empower and interact with the individual service user to increase his or her understanding and personal responsibility relating to life situation. Or, on the other hand, to distort their interprofessional alliances as a means of further marginalizing and controlling the service user.

The findings presented in this thesis also highlight the importance of continuous reflections among professionals and managers regarding empowering and collaborative practice, as well as the need to consider possible barriers in the organisational context. For example, by reflecting on how professionals use their power with reference to Braye and Preston-Shoot (1995) and to acknowledge ‘the dual faces of service user participation’ in regard to empowering and paternalistic processes which have been discussed earlier in relation to findings presented in Paper IV.

The findings may thereby contribute to learning and improvement processes to support the development of innovative service user-centred clinical microsystems in health and social care organisations. The meaning attributed to service user participation by service users in interview situations (Paper III) can be concluded to be a socially constructed meaning intertwined with
the person’s social situation and other experiences, but also as representing a sort of ideal – what participation could be like. In that respect, conceptions of service user participation can be applied as incentives for user-driven quality improvement in order to respond to those conceptions. In addition, the findings stress the need for a continuing reflection on practice and on whether marginalisation processes and paternalistic structures put restrictions on the meanings possible for service users to ascribe to the phenomena of service user participation. This must be accompanied with an awareness of the peril of naivety and oversimplifying empowerment endeavours as organisations themselves are based on unequal power conditions (Meeuwisse, 1999).

The findings support the potential for members of the interprofessional team to further employ a service user perspective by understanding and recognising the various ways of experiencing participation and to adapt to each individual service user’s conceptions of service user participation in interprofessional practice. By employing a view that people may construct social citizenship in terms of exerting the social rights to act as a citizen in multidimensional ways - acknowledging both the uniqueness of each person and of existing limitations and power structures - possible gaps between formal regulations advocating service user participation and actual practice in the clinical microsystem may be bridged.

In order to support the practical application of the findings, a conceptual model for service user participation in clinical microsystems is formulated below. The conceptual model (Figure 4) is developed by inserting the image of the clinical microsystem framework (see chapter 2) into the above outlined condensed summary of five descriptive categories ordered hierarchically due to complexity, drawing on findings from the perspective of both participant services users and professionals. The conceptual model is built considering that conceptions of being totally in control as a service user are not discernable in the above presented findings (Papers III and IV). The model contains an inner circle symbolising the clinical microsystem, with the interconnections between various conceptions of service user participation indicated with arrows.
Figure 4. A conceptual model of service user participation in interprofessional microsystems.

The descriptive category *Taking part in activities and social events* is located at the bottom of the inner circle, and is thereby positioned outside the interconnected arrows between the other descriptive categories because this category was not explicitly apparent in conceptions explored in the interviews with the participant service users. Furthermore, the following descriptive categories *Information transmission* and *Choice, decision and self-determination* are positioned next to each other, implying that both are interconnected with each other but not heavily dependent on conscious interactions and proximity between the service user and the various
professionals. The next descriptive categories *Communication and mutual relationship* and *Interacting with team members for increased understanding and personal responsibility relating to life situation* are positioned according to complexity.

Finally, the dimension of organisational conditions for service user participation is positioned outside of the inner circle referring to meso- and macrosystems and other contexts. The dimension of individual conditions/circumstances is positioned at the clinical microsystem interface indicating the individual person’s resources in the everyday context of the family, friends and other significant others as the primary microsystem according to ecological approaches (cf. Bronfenbrenner, 1995). An alternative position may be to depict the individual conditions at the very centre of the model due to the significance of the individual’s own situation and resources.

One advantage of the conceptual model depicted in Figure 4 is that it acknowledges that collaboration in terms of service user participation can be more or less complex, but also that service user participation can have various and evolutionary features.

The model may thus be adapted to the individual service user, and the focus of participation can be ‘placed’ anywhere in the circle according to the individual needs and preferences. The focus for empowerment processes and the participation of the service user can also evolve and change during the course of a person’s encounter with the professionals within the clinical microsystem.

The model has thereby potentials to respond to Tritter and McCallum’s (2006) criticism of Arnstein’s ladder model (1969), described earlier, which states that the model “fails to capture the dynamic and evolutionary nature of user involvement” (Titter & McCallum, 2006, p. 165). Furthermore, the model may respond to needs expressed by Nikander (2003) to allow for increasing the heterogeneity of clienthood in an ageing society and to understand how aspects of clienthood, such as the ‘active participant’, are constructed in practice.
Continuing reflection and interprofessional learning

Adams et al. (2005) claim that transformational practice and empowering processes may achieve both transformation of the setting for practice, the policy context and the professionals themselves with enhanced capacity for self-evaluation.

The findings regarding discursive patterns emerging in team members’ talk (Paper I) imply further challenges for team members to reflect on practice with the intention not to allow processes of discursive group formation (Winther Jorgensen & Phillips, 2002) and group think (Janis, 1982) to limit the strive for a service user perspective. For example, if a team member has ethical concerns about a team decision it is important that the team member voices these concerns in a manner consistent with the wellbeing of the service users (cf. National Association of Social Workers, 2008). Another challenge for the team members is to constantly reflect and support each other, not letting the discursive resources of knowledge synergy exclude the service user and the family and thereby thwart partnership with and empowerment of the service user.

The findings concerning perceived difficulties in interprofessional collaboration indicate that team members developed various strategies for managing perceived difficulties (Paper II). The points of departure for the upcoming discussion are that involvement in interprofessional teamwork entails experience-based lifelong learning for the professional (Drinka & Clark, 2000). Moreover, that experiences of managing difficulties are seen as learning opportunities and, as described by (D’Amour et al., 2005), that collaborative processes contain empowerment potentials based on knowledge and experience.

The study indicates that the strategies applied by professionals to handle perceived difficulties involved various forms of interprofessional learning (that is, learning that arose through interaction between the professions) and that the implications of the strategies varied depending on whether the difficulties were managed in open joint discussions or not (Paper II). From a learning perspective, a supplementary picture including four different
learning situations emerges through an analysis of the empirical findings previously presented in table 5 in the chapter, Findings. The learning situations are dependent on whether the difficulties were perceived as having been managed in joint discussions (reflection and planning) and resolved (action and experience). The following argument is based on the assumption that all four situations provide potential for interprofessional learning, but of different types (Table 6).

Table 6. A conceptual model of different learning situations considering perceived difficulties in interprofessional collaboration

<table>
<thead>
<tr>
<th>Difficulties resolved</th>
<th>Difficulties not resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Talk among the entire team</strong></td>
<td>Field 1: <em>High potential for empowering interprofession learning</em></td>
</tr>
<tr>
<td>Field 2: “Uniting force inwards, weak team drive outwards”</td>
<td></td>
</tr>
<tr>
<td><strong>No talk among the entire team</strong></td>
<td>Field 3: “This team is not suitable as a common resource”</td>
</tr>
<tr>
<td>Field 4: <em>Low potential for empowering interprofessional learning</em></td>
<td></td>
</tr>
</tbody>
</table>

Situations involving both joint conversation and resolution are reflected in field 1. One interpretation is that difficulties the entire team talked about and which were apprehended as resolved could constitute a source for empowering interprofessional learning. The learning may be described as a complete action-cum-learning cycle (Ellström et al., 2000) and may thus also reinforce the team’s interprofessional work. The situations in field 2 in which all professional groups talked about the difficulties together but did not arrive at a resolution may be perceived as constituting a uniting force inwards for the team members, but can also involve learning that the team’s drive and goal attainment are weak. The two remaining fields concern difficulties about which the team rarely talk as a group. Interprofessional learning in the team is obstructed because the experiences are seldom dealt with in joint reflection, and consequently, these experiences have a low potential for leading to joint action and experiences.
The different learning situations portrayed in Table 6 may be applied in connection with self-evaluations in the team and in situations when the team is supported by a facilitator. Possible questions include: What difficulties do we manage in joint discussions? What different aspects are found in the team’s various ‘fields’? In such cases, are these fields best managed individually or jointly? Are there any advantages or drawbacks to bringing up the issues in joint conversations? How might these strategies affect the team’s interprofessional learning and user-centred practice? Note that the team members’ sense of security must be considered in relation to such group reflectiveness situations.

**Implications for meso- and macrosystems**

As stated in chapter 2, collaboration between front-line professionals and service users takes place within larger organisations and is affected by both organisational and systemic factors (D’Amour & Oandasan, 2005; San Martin-Rodrigues et al., 2005). Here, the macrosystem represents the whole organisation and the mesosystem represents the major divisions of the organisation (Batalden et al., 2007). Furthermore, the microsystem approach employed in this thesis emphasizes the efforts of the whole organisation toward the small clinical microsystems where the service users are in direct contact with the health and social care agency.

The findings in this thesis have several practical implications in regard to leadership aspects of mesosystems in health and social care organisations. The findings reported in Paper I suggest that the discursive patterns identified in team members’ talk provide powerful and empowering resources, and in one respect this can be apprehended as an important advantage for the whole organisation in regard to service user-centeredness. However, the discursive resource for team members to claim superiority in relation with ‘the others’ poses challenges for meso- and macrosystems to support the actors in clinical microsystems so that they do not exclude collaboration with other service providers and networks both inside and outside the own organisation. One practical implication of the findings for
managers at meso and macro levels is they may facilitate and aid in understanding the internal processes in the interprofessional team.

The findings on difficulties perceived by members of interprofessional teams (Paper II) identified a theme labelled ‘the influence of the surrounding organisation’ consisting of the three sub-themes ‘hierarchical valuations’, ‘changes of organisation and setting’ and ‘team could not be made up of the right professions’. It is not entirely unusual for collaborative ability among practitioners to be developed without tangible or persistent support from the organisation (Beyerlein et al., 2004; Pritchard, 1995). Changes in types of collaborative practice such as team organisations are often made without insight into how these differ from traditional bureaucratic working models (Turniansky & Hare, 1998), and it is not considered enough simply to encourage teamwork (Scott Poole & Real, 2003). The capacity to identify and coordinate professions and skills in the team is crucial for professionals to respond accurately to the service user’s problem (Drinka & Clark, 2000; Hornby & Atkins, 2000; Øvretveit, 1997). However, the findings in Paper II indicate weaknesses in management at the levels above the micro level in allocating optimal resources to the clinical microsystem to exercise this essential team skill and thus providing the prerequisites the team needs to employ a service user perspective.

Furthermore, both service users and professionals attributed service user participation to organisational conditions (Papers III and IV) which have implications for the meso- and macrosystems. Several other studies position organisational aspects, such as lack of organisational responses reported by Carr (2007), as barriers to service user participation. In an interprofessional context the lack of available funding for interventions aimed at involving the service user in interprofessional treatment planning is perceived as a barrier to service user participation (Butow et al., 2007). Beresford (1993) points out that managers as well as politicians cannot pass over the issue of service user involvement to front-line practitioners but instead must take an active part in the process. L. Shaw (2004) points out that systemic barriers for participation are only discernable in the actual interactions between the service user and the professionals. Thus there are even higher demands on
managers at meso- and macrosystems of the organisation to discern and address such barriers.

**Implications for social citizenship**

The initially described Swedish government concerns for strengthening citizen participation form part of welfare state development, which since the 1980s has increasingly seen the citizen as active, responsible and cooperating with civil servants (Dahlstedt, 2008), a notion which in this thesis is transferred and specified into service user collaboration with multiple front-line professionals in the clinical microsystem.

According to Johansson and Hvinden (2007b) the call for active citizenship comes from both radical and conservative standpoints. Here, derived from the findings of this PhD project, the implications for active social citizenship draw on various orientations of new public management philosophy combined with liberal understandings of social citizenship as outlined by Johansson and Hvinden (2007b) and Bauman’s (1998; 2002) analysis of a consumer society.

Johansson and Hvinden (2007b) note that a normative emphasis on citizen activity takes place regardless of various liberal understandings of social citizenship, such as those formed by socio-liberal, neoliberal or republican understandings of citizenship. In practice all these constructions of social citizenship are intertwined and are exercised simultaneously within various segments of health and social care services. With a social-liberal understanding of social citizenship, activity is connected with fulfilling duties in return for services provided by the welfare state, while neoliberal/libertarian approaches on the other hand ideally avoid interventions of the state and the active citizen is expected to exercise choice and to fulfil her or his individual self-responsibility in a private welfare market. Finally, a republican construction of active social citizenship emphasizes participation in deliberation and decision-making in common affairs, along with self-governed activity and co-responsibility or, adapted to more passive approaches, a citizenship that focuses on “managed
participation in terms of user involvement, informed consent, or agency-directed self-help” (Johansson & Hvinden, 2007b, p. 44).

The above-described constructions of active social citizenship can be applied to the findings regarding variations of conceptions of service user participation that are presented in Papers III and IV, which are also further conceptualised above in figure 4. The ‘participative service user’ is constructed by both the service users and professionals that were included in the studies as being active to varying degrees, for example by making choices or by interacting with professionals. The meaning ascribed to the concept of service user participation as self-determination and having informed consent when obtaining information on rights and alternatives (Paper IV) relates to a republican understanding of citizenship. However, it does not fully expand to a republican view positioning citizenship as to be in control and make decisions in common affairs in, for example, user-controlled service provisions. Meanwhile, according to McLaughlin (2009), to conceive of participation as exercising choices and decisions among resources that involve the dimension of choosing among specific service institutions (Paper III) relates more, as has previously been noticed, to a consumer role. This way of conceiving participation can thus be said to relate to neoliberal understandings of citizenship as well as to new public management efficiency orientations as described by Ferlie et al. (1996).

The welfare state is often seen as the guarantor of common welfare. However, according to Bauman (1998; 2002), when a society is defined as a consumer society this requires that conditions are equal among citizens, which generally they are not. Those who do not have the option of being able to act as consumers are therefore socially degraded and excluded. Despite the growing focus on service user involvement in the Nordic welfare states Lister (2003) concludes that the marketization of the welfare and contract culture reflects a narrower liberal conception of citizen rights, as services are contracted out to non-state providers, a notion which here is interpreted as a neoliberal position. According to Lister (2003) this means that the rights involved are those of contracts rather than citizens’ rights against the welfare state, and she warns about implications regarding both access to and the quality of services provided in the long run.
An analysis of the implementation of a new public management philosophy in Swedish public services concludes that there are signs of deinstitutionalizing processes that pose challenges to democratic values (Agevall, 2005). Agevall suggests that narrow definitions of social citizenship, such as the individual contractual relationship, where the individual’s interest with the welfare state is stated only as personal benefits, tend to weaken the collective perception of solidarity support for welfare and lead to the destabilisation of public trust in welfare state services; a point which has also been considered, for example, by Taylor-Goby (2008).

Furthermore, the demand for activity that is imposed on the citizens in their relations with the health and social care services represents a form of power and control exercised by the front-line professionals and must be analysed as such (Dahlstedt, 2008). This is a notion which in this thesis is discussed in terms of professionals’ potential to exercise both paternalistic power or to initiate empowerment processes. Consequently, the construction of the active and participating service user contains democratic potential for social citizenship to actually be exercised in terms of both being and acting as a citizen. As was reported earlier, Johansson and Hvinden (2007a) note that the development towards active social citizenship is promoted both by structures of governance and by self-directed citizen demands in mutually reinforcing processes. Thus, derived from empowerment theory again and referring to Renblad (2003), empowerment is seen as a philosophy with democratic and ethical ideals about valuing people as equals who have their own strengths. One challenge, however, is to find ways of enacting social citizenship both collectively and individually; at societal and organizational levels as well as in interprofessional clinical microsystems.

Methodological considerations

According to Whittington (2003b) research on collaboration and partnership can be based on the application of three main approaches: 1) evaluation research with a post positivist paradigm studying implementation programmes and comparing ‘what works best’; 2) a critical perspective
exploring concealment of power and seeing evaluations as contributing to emancipation, and 3) a constructionist perspective asking how collaboration is constructed and negotiated, and exploring how collaboration is accomplished by those involved.

It can be concluded that the theoretical and methodological perspective of this present PhD project has mainly drawn on the latter constructionist approach, and has thus supplemented and contributed to the knowledge area of collaboration. The methodological approaches of the studies have contributed to increased understanding of the everyday context which social workers and other professions exist within, i.e. an interprofessional context in health and social care organisations. Further on, the PhD project has been aiming to take into account the premise that the explored concepts regarding collaboration are socially constructed and discursive.

The thesis does not contain evaluations of service user-centred orientations or the efficiency of interprofessional teamwork; neither does the thesis take into account issues regarding collaboration between agencies. Those aspects of collaborative health and social care are important, but are not within the scope of the PhD project as its main interests are the individuals’ understandings of collaborative interactions within the context of clinical microsystems in organisations.

The data production in Paper I was performed within the context of ‘the good team’, and the interview design itself did not encourage dissenting opinions. Consequently, the approach of centring attention on collective self-presentations tended to conceal power and gender differences among the participants. The perspective of discursive social psychology that was used in this study may have reinforced these aspects; where for example, employing a critical discourse theory-perspective (Fairclough, 1992) might have focused more attention on power positions. These aspects were in some respects balanced by performing individual interviews in the following studies (Papers II, III and IV). However, it can be concluded that all the studies included in the thesis are embedded in a general societal contemporary discourse that promotes active citizenship in terms of participation and collaboration in addition to teamwork which affected
persons participating in the PhD project, and thus the overall findings at a meta-level. This has also been discussed under the earlier subheadings of ethical considerations in chapter 4 and implications for social citizenship in chapter 6.

Furthermore, the employed research strategies have not allowed the author to investigate the service users’ individual interactions with each specific profession (Paper III) or to distinguish the individual participants’ professions in the material (Papers I, II and IV). Therefore, conclusions cannot be drawn about the eventual impact of these factors on findings. In order to perform such analyses other approaches involving a higher number of participants would have been necessary, thereby risking the integrity of the qualitative aspects of these findings. Besides, there are different sub-specialties within professions which can show large variations among themselves. Through analysing the material by distinguishing between professions there was a risk of presenting each profession as homogeneous and thereby possible to reduce in specific and simplifying ways. Moreover, the study designs employed in Papers III and IV did not allow separation of the identified variations of conceptions of service user participation from variations likely to be found in uniprofessional settings, which may be viewed as a limitation. Nevertheless, the studies have enabled the author to highlight specific interprofessional dimensions, thereby contributing to further understanding of collaboration in health and social care.

The participation in the interviews of the professionals (Paper IV) was fairly small in comparison to the ideal amount in phenomenographic-oriented studies as it is desirable to have at least 20 interview persons (Larsson, 1986). The small sample was due to the number of professions in the participating teams. However, since the participants were spread across different activity areas, the number of interviews was estimated to be large enough to obtain sufficient variation of conceptions. Moreover, there were more female than male participants in the four studies; therefore a gender perspective taking into account the experience by men is not highlighted. Furthermore, as female service users may have more emphasised preferences for affecting their services (Möller, 1996) and since female professionals are more likely to support user participation (McCann et al., 2008) the fact that
there was a majority of women in the sample may have influenced the perceptions of service user participation reported in Papers III and IV. Nevertheless, at the time of the data generation, the groups from which inclusions were made were dominated by women in a Swedish context (Statistics Sweden, 2009; Swedish Association of Local Authorities and Regions, 2009a, 2009b; Swedish National Board of Health and Welfare, 2005b). Thus the sample was in that respect equivalent to the existing distribution between women and men in those groups of people.

**Trustworthiness, transferability, and the significance of context**

The issue of trustworthiness (Lincoln & Guba, 1985) has been addressed by accounts of sampling and analysis strategies of the four studies presented in chapter 4. Furthermore, descriptions have been provided of the analytical process of each study. In all studies longer extracts of empirical data material as well as findings have been scrutinized prior to publication in various analysis seminars with the research group of that time, together with the co-authors (Papers I, III and IV), or a senior researcher (Paper II). The preliminary findings of most of the different studies in this thesis have been processed in sessions together with front-line practitioners; a process which is comparable to respondent validation (Silverman, 2010). In one of the studies, preliminary sub-themes and the relevance of the themes were verified in a session with an interprofessional team active in an area closely related to the participants, after which adjustments were made (Paper II). Follow-up dialogues with former participants (Paper III) and reflection seminars with former participants and their colleagues were performed as part of the analysis process (Paper IV).

The dimension of transferability is an empirical question depending on the similarity between the context of the study and another context, or the same context at another time (Lincoln & Guba, 1985). The findings are not transferable to other settings without further estimations being made or being generally applicable to an overall population of service users or professionals. In this thesis, efforts have been made to provide descriptions of participants and settings so that the reader can reach his or her own
conclusions. The findings presented in this thesis have provided increased knowledge of collaboration and empowerment processes in health and social care that may be transferrable to other areas within social work, such as the areas of disability or drug misuse.

It may be concluded that the findings concerning constructions and perceptions of service user participation (Papers III-IV) can be transferred mainly to contexts that are characterised by the absence of service user control structures such as collective user-controlled service provision or direct payment systems. Furthermore, the findings concerning the phenomena of service user participation are more likely to be transferred to settings where the person entering the health or social care service has not been subjected to compulsory admission to service. Other contextual considerations for transferability are that findings concerning the phenomena of service user participation are not likely to be transferred to temporary situations but instead to settings where the contacts between service users and the professionals take place over a longer period of time.

The contribution of the interactive research approach (Papers III and IV)

The decision to apply an interactive approach in the PhD project was prompted by the desire to obtain congruence between the research aim and the research strategies, i.e. that studying collaboration ought to be performed in collaboration. As interactive research according to Dominelli (2005) is one of the distinctive elements of social work research, the interactive approach applied in parts of this PhD project may have been applied in other studies besides Papers III and IV.

The contribution of the interactive approach to the research process has however, in spite of the above-mentioned limitations in scope, been valuable because of the creative processes and active contribution from the participants. For example, initial discussions with professionals and managers regarding their aims for the research collaboration and their contributions to the interview guide used in the study presented in Paper III
were important to ensure the potential of the research findings was of interest to the practitioners and to enhance the possibility for practical applications. An ethical dilemma identified during the PhD project was the protection of participant confidentiality in connection with analysis seminars, which further emphasises the researchers’ responsibility for rigour (see chapter 4 Ethical considerations).

Another consideration is to ensure that participant involvement in interactive research is not reduced to tokenism (cf. McLaughlin, 2010). It can be concluded that the joint reflection seminars with professionals, and follow-up dialogues with several of the former participants in their roles as service users provided learning opportunities regarding alternative ways of ordering the preliminary descriptive categories and has been included as an ingredient of ongoing improvement processes. However, the learning aspects should have been better explored during the research process in order to arrive at further conclusions. Nevertheless the interactive dialogues provided resourceful inputs, for example regarding the development of the conceptual model for service user participation in the interprofessional microsystems depicted above (Figure 4).

The relevance and contribution of the microsystem approach

In this thesis, the conceptual framework of clinical microsystems (Batalden et al., 2007) has been applied mainly as the study unit. It can thus be concluded that the quality improvement approach offered by the microsystem framework has not been fully employed. Moreover, the clinical microsystem framework has been rather difficult to delimit as research data sites and the strategies to operationalise the clinical microsystem framework have been described earlier in chapter 4 Methodology. The concept of clinical microsystems has to a certain extent not yet been implemented in practice. Despite these objections, experiences have been positive in terms of the relevance and contribution of the conceptual framework to distinguishing the team and the service user and their organisational positions in the wider
institutional settings, as well as within the policy context of laws and societal value systems.

Thus, it can be argued that microsystem approaches offer a number of contributions related to the area of service user participation and interprofessional teamwork. One issue which recurs within the literature on collaborative health and social care on the face-to-face level is the integration between the service user and the team. For example, Thistlewaite (2008) poses the question of whether the service user is a part of the team or is only viewed as a recipient of its care, thereby implying that inclusion in the team is the most desirable option. D’Amour et al. (2005) concludes that, although that the needs of the service user are put forward as the prime reason for collaborative care, there are disagreements considering the preferred role of the service user in the team, and few attempts have been made to explore and determine how the service user could be integrated into the team.

The findings reported in Paper I show that the professionals, in their talk about their team, positioned the service user when using both the inclusive ‘we’ and the more distanced ‘them’. This is a feature that indicates transitions between various discourses (Winther Jorgensen & Philips, 2002) on how to construct and experience collaboration with the service user. Some possible contributions to these dilemmas concerning the membership of the service user in the interprofessional team can be presented by applying ecological and clinical microsystem approaches. The ecological approach acknowledges the individual person in the context of their family and other significant others as the primary micro system and the person's contacts with health and social care agencies in the role as a service user as a secondary form of community, which together form mesosystems. Thereby, it is emphasised that the individual's contacts with health and social care represent only one of many contexts, and the service user's wish to be fully included in the interprofessional team can thus be questioned. The service user's right to decline collaboration must be acknowledged. Beresford (1993) also notes that the individual may well prefer not to receive the service at all.
By a clinical microsystems approach, the service user with the family, along with the team, are considered as being parts of the same clinical microsystem. In this perspective the service user is the reason of the existence of the clinical microsystem in the first place, but the service user is thus not viewed as a part of the interprofessional team. The service user's membership, i.e. membership in terms of membership activities producing interactional structures (Hilbert, 1992), may, in other words, be apprehended as directed towards activities in the clinical microsystem.

Through a microsystem approach, the team's internal processes become distinctively an affair for the professions, with a focus on interprofessional and professional knowledge and the possibilities and constraints that the organisation puts on the members that are employed by the organisation. With this approach the conflicting interests between service users and professionals as mentioned above with reference to, for example, Henneman et al. (1995) do not run such a great a risk of being disregarded or hidden. The interprofessional team is thereby given the opportunity to act on both so-called ‘frontstage’ and ‘backstage’ arenas with reference to Goffman (1959) and Sarangi and Robert (1999), without minimising the eventual ambition of service user participation. Put in other words, ‘front stage’ refers to activities where the team's so-called performance is played out in interaction with the service user, whereas ‘backstage’ refers to contexts where the service user is absent. The team members’ mission is thereby not primarily to create participation and inclusion by facilitating the service user's integration in a backstage group of people who have the advantage of already knowing each other and who, through their professional position in the institutional context, have much more power in comparison to the service user. On the other hand, the team members must not view the service user merely as a recipient of their care. Instead, the mission of the team can be formulated so as to accumulate the appropriate professional, administrative and information technology resources around the service user and the family. The members of the team should, in other words, ideally facilitate participation and empowerment where the service user is the expert-by-experience and a co-creator. They do this by transforming themselves into the ‘team of the service user’ and use their interprofessional knowledge synergy for the increased well being of the service user.
A further aspect which clinical microsystem frameworks might contribute to concerning the area of collaboration is the following view that the essential tasks of meso- and macro systems are to provide support to the multitude of so-called ‘sharp end’ Microsystems, as according to Batalden et al. (2007) the quality of the whole organisation can be no better than the quality produced of these small systems. The findings in regard to organisational factors for interprofessional work (Paper II) and service user participation as organisational conditions/circumstances (Papers III and IV) also support the importance of supportive organisational and managerial structures. The need for flexibility, which is prominent in interprofessional collaboration, places demands on the organisation to change its structures and provide space for action in order to respond to the demands of the service users (Wilmunsen, 2006). The suggested need of space for action in interprofessional practice can thereby be considered to touch upon the concept of street-level bureaucracy formulated by Lipsky (1980). Street-level bureaucrats are the front-line professionals in public organisations who meet service users in their daily work, and who act as representatives for the organisation and who through their professional authority and actions embody - they are - the public policies experienced by the service user (Lipsky 1980). In studies of Swedish home help, Szebehely (1995) points out the need for activity space to allow the front-line professionals to achieve a balance between caring for [Swedish: sörja för] and caring about [Swedish: sörja med] the service user.

Two contrasting tendencies in the welfare sector regarding professional discretionary space can be discerned. According to Möller (1996), increased goal orientation and decentralisation in Swedish municipal activities can give an increased discretionary space for front-line professionals. At the same time, critical voices have pointed out that political reforms directed towards the welfare sector have recently curtailed professional discretionary space, both in Sweden and other European countries (Ellis et al., 2002; T. Evans & Harris, 2004; Szebehely, 1995). As reported earlier, Beresford (1993) also states that disempowering processes within organisations affect the front-line practitioners. Thus it follows that the notion of professional discretion and front-line autonomy might even have relevance for the clinical microsystem framework with its emphasis on the front-line units. This notion may also be considered to be consistent with the Canadian
framework for collaborative client-centred practice formulated by e.g. D'Amour and Oandasan (2005).

In sum, the framework of clinical microsystems with its quality improvement origin may be considered as a part of the earlier described efficiency management approach concerning organisational research on teams, as well as a positivist paradigm when studying collaboration, with a tendency of contrasting empirical findings with a normative efficiency position. However, by applying social constructionism in addition to pedagogical and interactive approaches a perspective has been adopted in this thesis which acknowledges the importance of knowledge development concerning how service users and professionals experience collaboration in the interprofessional context of clinical microsystems. Thus, it is acknowledged that interactive processes create the social reality for the members (I. Shaw & Gould, 2002) a notion which may be considered to be included in the framework. Furthermore, the exploration of variations of service users’ conceptions of social phenomena such as service user participation (Paper III) may serve as a substantial input for service user-driven quality improvement in practice. The clinical microsystem is thus also considered as a place for learning processes for both front-line practitioners and service users, comparable to learning communities of practice (Wenger, 1998). This is reflected in Adams (2008) when he states that teamwork, partnership, and networks across boundaries can be effective for organisations transforming into learning systems.
7. Concluding remarks and suggestions for further research

This thesis addressed the relationship of citizens with the welfare state with the aim of exploring how service users and professionals experience collaboration in health and social care. The key findings of the studies, i.e. Papers I–IV, as well as the discussion of the findings, are summarised in the following concluding remarks.

This thesis contributes to our knowledge about collaborations in health and social care and about conceptions of this collaboration that are based on the perspectives of various actors in the clinical microsystems, i.e. the local places where collaboration takes place and where the concepts underlying the welfare state buzz words are actually enacted. This PhD project also filled in some knowledge gaps that had not been previously explored or described in depth. For example, one contribution of the thesis is that it places the concept of service user participation in an interprofessional context. Specifically, it relates the various meanings that service users and professionals attribute to service user participation to empowerment and disempowerment processes as well as to constructions of social citizenship.

This thesis also contributes to knowledge in the field in that it reports findings regarding collective identity work and discursive patterns in interprofessional teams and also relates the difficulties associated with these kinds of teams to various learning situations. As well as making contributions that are concrete and have practical implications, the thesis also contributes to the ongoing development of the theory underlying the clinical microsystem framework by relating the empirical findings of the thesis studies to this framework.
Summary of the key findings and conclusions in this thesis:

Discursive patterns of interprofessional discourse render authority and provide empowering rhetoric resources for team members as well as the opportunity to share the concept of ‘we’ with the service user and with other professional groups. This discursive process creates bridges between professions.

Perceived difficulties in interprofessional collaborations may hinder the collaborating professionals from adopting a service user perspective, from arriving at a holistic view and from adapting the team's resources to better address the needs of the service user. The findings suggest that the potential of interprofessional collaboration may not be fully realized.

The interprofessional dimensions discernable in the variations of how to conceptualize the phenomena of service user participation are mainly understood in terms of increased opportunities for service user participation, such as opportunities to understand and assimilate information and to equalize the professionals’ expert roles. Furthermore, it may be that by understanding and utilizing these various perspectives, the multiple front-line practitioners can further empower and interact with the individual service user and increase his or her understanding and personal responsibility as related to the life situation. By acknowledging both the uniqueness of each person and of existing limitations and power structures - possible gaps between formal regulations advocating service user participation and actual practice in the clinical microsystem may be bridged.

Notably, the concept of service user participation cannot be entirely related to the issue of choosing among available resources, as has been advocated by neoliberal constructions of active citizenship. That is, collaboration in terms of service user participation cannot only be comprehended as contract relationships between consumers and service providers. The findings indicate that service users and professionals perceive that there are several other ways to act as a
citizen and for people to exercise human agency in relation to the welfare state. This thesis suggests that the various conceptions of service user participation in interprofessional practice encompass dimensions that include themes of togetherness, understanding and interaction within the clinical microsystem.

Suggestions for further research

There is a need for further research that addresses the relationship of citizens with the welfare state with a focus on collaboration between service users and professionals, as well as on collaboration among health and social care professionals themselves.

Zwarenstein et al. (2009) suggested that future research should focus on collaboration conceptualisation and measurement. As stated above, this thesis contributes to collaboration conceptualisation by exploring the meaning of various collaboration concepts or so-called welfare state “buzz words” as constructed and experienced by front-line practitioners and service users.

However, research that addresses measuring collaboration efforts, or evaluations research as described by Whittington (2003b), requires other theoretical perspectives and inquiry strategies than those used in this thesis. Further research should address questions related to outcomes and should include more participants, and more types of participants, at different sites. The design of future studies may also encompass, for example, the conceptual model of interprofessional learning situations and the conceptual model of service user participation in clinical microsystems as presented in this thesis. Such models could be applied and verified through interventions in various health and social care practices. Exploration of the interrelation of service user variability and specific circumstance variability might contribute to our understanding of service user participation in interprofessional clinical microsystems and bring some answers to the question, ‘What works for whom, and when and where does it work?’
Future research might also examine the dimensions of collaborative processes that involve family members as well as local members of the community. Future research could explore the implications of increased use of information technology and information systems in health and social care, with a focus on the potential of such technology to influence and change the collaborative relationships between service users and front-line professionals.

Finally, ongoing research should investigate how people perceive and exercise human agency in relation to the welfare state, how social citizenship is transformed and renegotiated by different actors over time and what this means for collaborative processes in health and social care in Sweden.
Avhandlingen behandlar medborgarnas relation till välfärdsstaten, med forskningsintresset riktat mot brukardelaktighet och samarbete mellan olika grupper inom svensk vård och omsorg.

Medborgarens egen aktivitet i kontakterna med välfärdsstaten har betonats i Sverige och i andra västeuropeiska länder sedan slutet av 1900-talet. I sina roller som brukare förväntas medborgare vara aktiva, ta ansvar för sin egen välfärd och samarbeta med personer från olika yrkesgrupper. Utövandet av det aktiva medborgarskapet i mötet med välfärdssystemen sker med andra orden ofta i en interprofessionell kontext där flera professioner är inblandade.

Ett grundantagande i den här avhandlingen är samtidigt att brukarens relation till de professionella som företrädare vård och omsorg präglas av en maktobalans till de professionellas fördel. I detta avseende betraktas sociala fenomen kring samarbete vara av betydelse i varje enskilt möte mellan brukare och professionella. Vidare knyts aktivt medborgarskap i form av brukares samarbete med de professionella till empowermentprocesser, där de professionella förväntas möjliggöra brukarnas aktiva delaktighet. Via olika styrdokument såsom Socialstyrelsens författningar om ledningssystem för kvalitet tydliggörs samhälleliga förväntningar på att de professionella ska
vara aktiva och involvera den enskilde brukaren, men även samarbeta tillsammans med andra professioner för att uppnå kvalitet i verksamheten.

I den här avhandlingen betraktas begreppen delaktighet, empowerment och teamarbete vara socialt konstruerade och perspektivberoende, där begreppen uppfattas olika beroende på medborgares olika relationer till välfärdsinstitutionerna. Utgångspunkten är därmed att det förekommer kvalitativa skillnader i hur människor tillskriver olika sociala fenomen samt att människor agerar och interagerar i förhållande till dessa uppfattningar. Personers språkanvändning och förståelse av olika begrepp kring samarbete betraktas alltså som fundamental för att förstå det vardagliga mötet mellan professionella och brukare och mellan olika professionella inom vård och omsorg. Då begreppen också ingår i den grupp av de ”modeord” som förekommer inom vård och omsorg har dessa bedömts vara av vitalt intresse att studera inom ramen för föreliggande avhandling.

Övergripande syfte och metod

Avhandlingens övergripande syfte var att utforska hur professionella och brukare uppfattar samarbete inom vård och omsorg.

Avhandlingens övergripande teoretiska referensram var social konstruktionism och de fyra studierna som ingår i avhandlingen innehöll diskurs- och innehållsanalytiska, fenomenografiska och interaktiva studier. Det empiriska materialet baserades på transkriberade fokusgruppintervjuer och individuella intervjuer samt interaktiva uppföljningsdialoger och seminarier. Sammanlagt medverkade 87 deltagare i de fyra studierna, varav 22 personer deltog i rollen som brukare och 65 personer medverkade i rollen som vårdgivare. En majoritet av deltagarna var kvinnor. Studierna genomfördes vid två landsting och en kommun i Sverige och omfattade följande aktivitetsområden: äldreomsorg, primärvård, rehabiliteringsverksamhet, psykiatrisk verksamhet/psykisk hälsa samt sluten somatisk vård. Studieenhet utgjordes av organisationens mikrosystem, d v s den kontaktyta där brukaren, dennes familj och teamet möts. Teamen bestod av personer
från sammanlagt tio olika yrkesgrupper, såsom arbetsterapeut, socionom och sjuksköterska.

Avhandlingens studier

*Studie 1* syftade till att undersöka hur medlemmar i multiprofessionella vårdteam talar om sitt team. Teammedlemmarnas samtal analyserades med fokus på de diskursiva mönster som framträdde när teammedlemmar talade om teamet och vilken funktion dessa mönster hade. Fynden visade ett antal grunddrag vid användningen av orden ”vi” och ”de”. ”Vi” relaterades primärt till det egna teamet, medan användningen av pronomen ”de” kopplades till brukare, till personer som arbetade mer traditionellt eller som inte var en del av teamet. Brukaren relaterades med andra ord både till teamet och till ”de”. Variationen av inkluderingen av olika aktörer i det gemensamma ”vi” indikerade att teammedlemmarna fastställde vilka andra personer som tillhörde eller inte tillhörde teamet. De diskursiva mönster som framträdde i teammedlemmarnas konstruktioner av ”vi-som-team” benämndes *kunskapssynergi* respektive *tillitsfullt stöd*. Kunskapssynergi innehöll element såsom ”korsvist lärande” och ”två-kan-se-mer än-en”-metaforer. Tillitsfullt stöd innefattade faktorer som ömsesidig tillit, konsensusbeslut och familjemetaforer.

Syftet med *studie II* var att identifiera och beskriva svårigheter som teammedlemmar har uppfattat vid interprofessionellt teamarbete. Avsikten var även att möjliggöra en diskussion om implikationer för interprofessionellt lärande. I innehållsanalysen framträdde följande tre teman av svårigheter; teamdynamik, professionernas kunskapsbidrag, samt den omgivande organisationens påverkan på teamet. Subteman inom ramen för temat teamdynamik var att teamet bestämmer över individen/professionen, ett ojämnt ansvar för egna och andras uppgifter samt att andra yrkesgrupper går in på det egna området. Temat professionernas kunskapsbidrag omfattade subteman att kunskapsbidraget inte värderades likvärdigt eller togs till vara, bristande samsyn samt en ojämn fördelning av aktuell kunskap i teamet. Följande subteman identifierades vad gällde omgivningens
påverkan; hierarkiska värderingar, förändringar av organisation och miljö samt att teamet inte kunde sättas samman med rätt professioner.

Syftet med studie III var att undersöka och beskriva variationerna i hur brukare uppfattar brukardelaktighet, specifikt i ett interprofessionellt sammanhang. Fynden visade ett utfallsrum där brukares skilda sätt att uppfatta delaktighet formulerades i fem beskrivningskategorier A-E: (A) informationsöverföring, (B) val och beslut bland resurser, (C) trygg kontakt och kommunikation med personalen, (D) interaktion för ökad förståelse, samt (E) förhållanden kring delaktighet. Beskrivningskategorierna ordnades inbördes efter komplexitet, från relativt obearbetade handlingar rörande informationsöverföring till uppfattningar av delaktighet som mer komplexa interaktioner med personalen för en ökad förståelse av den egna livssituationen. Kategorin (E) förhållanden kring delaktighet, bedömdes ha anknytningar till samtliga övriga beskrivningskategorier. Den interprofessionella dimensionen av informationsöverföring var att brukaren endast behöver en ingång till de olika professionerna, som koordinerar sig sinsemellan. Den interprofessionella dimensionen av delaktighet som val och beslut hänfördes till att välja bland de olika professionella grupperna beroende av de egna behoven. Trygg kontakt och kommunikation innebar nära gemenskap och dialog med de olika yrkesgrupperna på lika villkor, medan den interprofessionella dimensionen av interaktion för ökad förståelse innebar att komma till insikt och förståelse genom samarbete med de olika yrkesgrupperna. Slutligen innebar förhållanden kring delaktighet bland annat brukarens förmåga att hantera situationer med flera parter.

Studie IV syftade till att undersöka och beskriva variationerna i hur första linjens professionella uppfattar brukardelaktighet, specifikt i ett interprofessionellt sammanhang. Ett utfallsrum bestående av sju kvalitativa variationer identifierades i studien. Variationerna ordnades hierarkiskt inbördes avseende på de uttryckta uppfattningarnas komplexitet utifrån aktivitet, interaktivitet och närhet. Variationerna formulerades som beskrivningskategorierna A-G, där brukardelaktighet uppfattades enligt följande: (A) ingå i aktiviteter och sociala sammanhang, (B) få vägledning, (C) ha självbestämmande och valfrihet, (D) bli bekräftad och få kontakt med personalen, (E) förhandling för anpassning (F) personligt ansvar genom
insikt samt (G) omständigheter kring delaktighet. Flera av beskrivningskategorierna inrymde variationer i form av subkategorier. Exempelvis innebar Förhandling för anpassning (beskrivningskategori E) att delaktighet tillskrevs å ena sidan som att verksamheten anpassas efter brukarens önskemål och å andra sidan att brukaren genom delaktighet accepterar verksamhetens ramar. Vidare innehöll de olika beskrivningskategorierna även skilda former av professionella roller. Den interprofessionella dimensionen av brukardelaktighet uppfattades av de professionella framförallt som att brukarens möjligheter till delaktighet förstärktes, t ex underlättades för brukaren att ta till sig vägledning då den gavs av flera yrkesgrupper.

Slutsatser

Studiernas resultat och efterföljande diskussioner i avhandlingen sammanfattas enligt följande:

- Diskursiva mönster i teammedlemmarnas tal om sitt team utgjorde retoriska resurser vilka gav teammedlemmarna auktoritet i förhållande till omgivningen. Likväl innebar dessa interprofessionella diskursiva mönster möjligheter för medlemmarna att konstruera ett gemensamt ”vi-som-team” som inkluderade brukaren och andra professionella grupper, vilket därigenom kan utgöra en brygga mellan professionerna i teamet.

- Konsekvenser av uppfattade svårigheter i interprofessionellt samarbete var att teamet förlorade i helhetssyn samt inte kunde anpassa teamets resurser efter brukarens behov och därigenom förhindrades att anta ett brukarperspektiv. Tolkningen kan därigenom göras att potentialerna med ett interprofessionellt samarbete inte utnyttjades fullt ut.

- En jämförande analys mellan brukares och professionellas uppfattningar av brukardelaktighet visade överlappande likheter men även gap. Brukardelaktighet i form av att delta i sociala sammanhang och vara allmänt aktiv var inte framträdande i brukarnas uppfattningar, medan
dessa konstruktioner däremot framkom i professionellas dialogsekvenser. Till skillnad från medverkande brukare poängterade de professionella som deltog i studien även brukarens eget ansvar. Kvalitativa skillnader i den mening som tillskrivs delaktighet mellan och inom grupper kan sägas ha implikationer för interaktioner i det vardagliga mötet i vård och omsorg.

- Vidare diskuterades i analysen av fynden att de identifierade variationerna av uppfattningar av brukardelaktighet, mer eller mindre explicit, kunde vändas till dess motsats, något som i avhandlingen benämndes för ”brukardelaktighetens dubbla ansikten”. Exempelvis kunde beskrivningskategorin ”Förhandling för anpassning” dölja ojämlika maktrelationer mellan brukare och professionella. Den interprofessionella dimensionen av delaktighet innebar därmed potentialer för både empowerment och paternalistiska processer.

- Dessutom innebar den mening som attribuerades till begreppet brukardelaktighet inte enbart olika variationer av att välja mellan ett utbud, d v s uppfattningar som kan relateras till neoliberalt socialt medborgarskap i ett konsumtionssamhälle och till kontraktsrelationer mellan konsument och leverantör av välfärdstjänster. Begreppet brukardelaktighet relaterades även till nära interaktioner och trygghet mellan brukare och vårdgivare för ökad insikt i den egna livssituationen, vilket därmed indikerar flera mångfacetterade sätt för medborgaren att vara och också att agera som medborgare.

Avslutningsvis kan konstateras att den här avhandlingen har bidragit till kunskap om medborgarnas relation till välfärdsstaten i huvudsak genom begreppsutveckling av förekommande begrepp och samhälleliga ”modeord” kring samarbete, såsom de uppfattas och konstrueras av aktörer som möts och förväntas samarbeta i vård och omsorg.

Avhandlingen har bidragit till kunskapsutveckling kring samarbete genom analyserna kring kollektiva identiteter, diskursiva mönster och uppfattade svårigheter vid samarbete i interprofessionella team. Vidare har kunskapsbidrag lämnats genom att beskrivningar av uppfattningar om
bruksdelaktighet har positionerats till ett interprofessionellt sammanhang och genom att dessa olika uppfattningar har relaterats till såväl empowermentteorier som teorier kring socialt medborgarskap. Dessutom innebär avhandlingen ett teoretiskt bidrag och praktiska implikationer genom att empiriska fynd relateras till den pågående utvecklingen inom teoretiska ansatser rörande mikrosystem.

Fynden i de olika studierna har omsatts till konceptuella modeller kring samarbete som socialt fenomen. En modell för olika interprofessionella lärandesituationer har formulerats genom att relatera fynden kring uppfattade svårigheter i teamarbete till teorier om lärande. En modell för bruksdelaktighet i interprofessionella mikrosystem har utvecklats genom att jämföra och kontrastera de olika meningar som brukare och professionella har tillskrivit begreppet bruksdelaktighet. Modellerna har potential att implementeras i praktisk verksamhet, både som grund för reflektion och förståelse av det vardagliga mötet, likväl som medel att identifiera möjliga marginaliseringsprocesser och hinder för empowerment av såväl brukare som vårdgivare. Fyndens praktiska implikationer är sålunda även att utgöra en inspiration för förbättringsarbete inom vård och omsorg.
## Acknowledgements

First of all I would like to express my warmest thanks to the persons who participated in the studies and to the local contact persons who together made this thesis possible.

I thank my supervisors, Elisabet Cedersund for infinite endurance and scientific guidance throughout the whole research process, and Boel Andersson-Gäre, Toomas Timpka and Berith Hedberg for your commitment, academic stringency and feedback. I am forever indebted to you.

Thanks also go to Kerstin Gynnerstedt, Monica Wilinska, Rickard Ulmestig, Björn Jonsson, Pia Bulow, Birgitta Ander, Katherine Stevenson and Bengt Fridlund for comments on the research plan and thesis manuscript. I thank Felicia Gabrielson Järhult for being my supportive mentor. Thanks also go to my family for persistent encouragement and loving support and also for contributing to the PhD project; therefore I thank Tove and Sanna for their painstaking transcriptions, Sanna for translations and Lasse for proofreading various manuscripts.

I thank my fellow doctoral students and staff at the Bridging the Gaps research program, the Research school of Health and Welfare and the Gral seminar group at Jönköping University, and the ‘Tuesday seminar group’ at Social Work and Tema Äldre, Linköping University.

I thank my colleagues at the Department for Behavioural Science and Social Work, Jönköping University and the Division of Social Medicine and Public Health Science, Linköping University. Thanks also go to all staff members of the R&D unit at Linköping and the Centre of Leadership and Improvement at the Dartmouth Institute.

Finally, I would like to thank the Glimpse group; Hugh Barr, Synnøve Hofseth Almås, Elisabeth Willumsen and Atle Ødegård for their disciplinary
and interdisciplinary collaboration. Also, thanks go to Smokey Robinson & the Miracles.

The PhD project has been financed by the Bridging the Gaps research program through Vinnvård with associated partners VINNOVA, Vårdal Foundation and the Ministry of Health and Social Affairs. Other sources of finance have been the County Council of Östergötland and Futurum, Jönköping County Council.
References


Leiba, T., & Weinstein, J. (2003). Who are the participants in the collaborative process and what makes collaboration succeed or fail? In J. Weinstein, C. Whittington & T. Leiba (Eds.), *Collaboration in social work practice* (pp. 63-82). London: Jessica Kingsley Publishers Ltd.


