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Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork

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Abstract
The challenge for members of interprofessional teams is to manage the team processes that occur in all teamwork while simultaneously managing their individual professional identities. The aim of this study was to identify and describe difficulties perceived by health professionals in interprofessional teamwork. Utterances on verbal actions and resolutions were also explored to enable a discussion of the implications for interprofessional learning. Individual interviews using a Critical Incident Technique were performed with 18 Swedish professionals working in healthcare teams, and examined with qualitative content analysis. The main findings show difficulties related to the team dynamic that arose when team members acted towards one another as representatives of their professions, difficulties that occurred when the members' various knowledge contributions interacted in the team, and difficulties related to the influence of the surrounding organization. The perceived consequences of the difficulties, beyond individual consequences, were restrictions on the use of collaborative resources to arrive at a holistic view of the patient's problem, and barriers to providing patient care and service in the desired manner. This paper also discusses how experiences of managing difficulties entailed various forms of interprofessional learning situations.

Keywords: *Critical incident technique, interdisciplinary health team, interprofessional learning, interprofessional relations, sociology of professions*

Introduction

Great hopes are currently pinned on improving the quality of public health and healthcare through interprofessional collaboration (Meads & Ashcroft, 2005). Interprofessional healthcare is expected to generate health gains, and has been related to both greater responsiveness to patients (Greenwell, 1995) and efficient use of resources (Loxley, 1997). Collaborative patient-centred care is associated primarily with work in teams (D'Amour et al., 2005). The task of individual team members is thus to reform healthcare where conventionally organized care has failed. As well as managing among themselves the team processes that occur in all teamwork, team members are expected to manage the competing agendas upon which their various professional identities are based (Lingard et al., 2004). From a sociology-of-professions approach, a professional logic may be described as the links connecting the aspirations of various groups for professional status with a view to strengthening their status in the labour market (Torstendahl, 1990). Greenwell (1995) notes that the team members' duty to report to their own profession's management structure

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creates ties outside the team, while Drinka and Clark (2000) emphasize that team members must learn to create a balance between the profession and the team. Consequently, the challenges facing the team are myriad, and require attention from the society that creates the conditions for collaboration among health professions in healthcare organizations.

Difficulties in teamwork among health professionals are abundantly described in the literature. However, a PubMed and CINHAL search of literature published over the last ten years (January 1996 – June 2006) produced only a few empirical studies that specifically used Critical Incident Technique (CIT) to systematically collect qualitative data via interviews focused on team members' perceptions of difficulties. These studies, by Atwal (2002) and Silen-Lipponen et al. (2004), each involved only a single professional group's experiences of interprofessional collaboration. Hence, the present study focuses on the collective experiences of all professional groups in the same team in situations where they are trying to collaborate in order to meet the patient's needs. In addition, by focusing on perceived difficulties and the management of these difficulties, this study can contribute to discussion of learning situations in interprofessional work. In this capacity, it relates to a CIT study of computer support in primary health care work groups by Timpka and Nyce (1992), which was based on the understanding that work procedures that are normally taken for granted can become objects for conscious reflection when difficulties or dilemmas arise.

The aim of this study is to identify and describe difficulties perceived by health professionals in interprofessional teamwork. It also explores utterances on verbal actions and resolutions, in order to enable discussion of the implications for interprofessional learning.

Teamwork and interprofessional learning

Interprofessional collaboration can assume many forms, and the concept of interprofessional teamwork can be defined in many diverse ways (D'Amour et al., 2005; Thylefors et al., 2005; Willumsen, 2006). Here, the prefix ''inter'' relates to the dimension of ''collaboration''. The degrees of interaction and mutual dependency among team members, and these members' responsibility for patient care, are understood here as a continuum stretching from ''multi'' through ''inter'' to ''trans'' (Hall & Weaver, 2001). This paper use the term ''profession'', thus differentiating from the term ''discipline'' in the sense that disciplines may be regarded as academic disciplines as well as sub-specialities within professions (Freeth et al., 2005). Teamwork is defined as ''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). Interprofessional learning is understood to arise from interaction among members of two or more professions (Ibid.); in this study, this is regarded as interaction among the professions in the team. Learning in teams is ideally seen as a circular action-cum-learning process involving experiences, reflection, planning, and action (Ellström et al., 2000). The concept of reflection may be related to Schön's (1991) descriptions of the reflective practitioner and the reflective conversation with others.

Method

Study design

The study was designed as individual interviews with health professionals working in teams, which were examined with qualitative content analysis. The interviews were conducted using Critical Incident Technique (CIT) via a semi-structured interview guide. CIT comprises a set of procedures for gathering facts on human behaviour in defined situations

in order to facilitate their potential usefulness in, for instance, the creation of solutions to practical problems. To be considered critical, the incident must occur in a situation where the intent and consequences of the incident are sufficiently definite (Flanagan, 1954). CIT has been advocated as a method for studying interprofessional work as decision-making (Rawson, 1994), and has been employed in studies within healthcare and educational settings (e.g., Bendtsen et al., 1999; Fallsberg & Hammar, 2000). It therefore seemed to be an appropriate method for the present study.

Experiences related to critical incidents in interprofessional teamwork were evoked by asking, ''Are there any difficulties involved in working together with several professional groups in the team?'' followed by, ''Can you remember a situation in the last year when you experienced such a difficulty?'' Once the situation was established, follow-up questions were asked to determine such details as the context in which the incident occurred, the consequences of the incident for the interview subject and for others, the actions that were taken by the actors involved, and whether the situation was eventually resolved. The interviews were recorded on tape and transcribed verbatim.

After the interviews, the participants provided background data as well as their understandings of the team's interprofessional approach. This part of the data collection employed a survey developed by Thylefors et al. (2005), and was aimed at deriving a description of the team characteristics of the sample. The survey includes both closed and open questions and covers the dimensions of role specialisation, task interdependency, coordination, task specialization, leadership, and role interdependency. Put together, these dimensions result in a team type index; a low score indicates a multiprofessional approach (i.e., additive, professions contributes independently), a median score an interprofessional approach (i.e., integrative, professions interact), and a high score a mainly transprofessional team approach (i.e., role blurring, boundaries between professions are partly dissolved). There are a great many known instruments for assessing effective teamwork in interprofessional settings (e.g., Farrell et al., 2001; Cashman et al., 2004; Curran et al., 2005); however, they do not capture the dimensions of multiprofessional, interprofessional, and transprofessional team characteristics as explicitly as the Thylefors survey.

The sample

The study population consisted of the members ($n = 18$) of four teams. The participating teams were drawn from an earlier study reported by Kvarnström and Cedersund (2006) in which all healthcare teams within one county council in south-eastern Sweden were invited to apply to participate in focus group interviews through a process called ''member-identified category sampling'' (Hammersley & Atkinson, 1995). The original six teams were reduced to four; one of the omitted teams was no longer active and the other was excluded due to high turnover. While the composition of these four teams had changed since the earlier study, their principal tasks were essentially the same.

The included teams worked within the local county council on both an interagency and an intra-agency basis. County councils in Sweden administer both primary care and teaching hospitals. As is the case with the bulk of healthcare in Sweden, the teams were financed with tax revenues. All teams were active in local healthcare [Swedish: närsjukvård]. In the Swedish healthcare model, local healthcare includes the operational sectors of primary care, psychiatric care, geriatric care, and rehabilitation; and there is longstanding experience of teamwork in the local healthcare system.

The sample of respondents was based on a stratified purposeful sampling strategy, a combination of maximum variation sampling and random purposeful sampling

(Patton, 2002). Maximal variation was achieved by including one individual from each participating profession in every team, 18 people all told (out of a total of 38 people) from nine professional groups. 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. The potential respondents were approached by letter, and agreement to participate was provided by either telephone or mail. All individuals approached agreed to participate in the study. The participating professional groups were: occupational therapist, registered nurse, physiotherapist, medical social worker, administrative assistant, physician, practical nurse, psychologist, and speech therapist. Fourteen respondents were women and four were men. 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 their team for 1.5 to 15 years and worked with the team for an average of 27 hours per week.

The study was approved by the local scientific ethics committee. Written consent was obtained from the informants, who were assured of anonymity and that they could withdraw from the study at any time with no explanation whatsoever.

Data analysis

Qualitative latent content analysis was used to identify the significant underlying meaning from the texts of the interviews (Downe-Wamboldt, 1992; Morse & Field, 1996). A total of 40 distinct critical events were identified in the 18 interviews (median per interview 2, range 1–4). These events were extracted from the text as meaning units, each of which covered the incident and its consequences. The meaning units were first condensed into descriptions closely related to the text. The descriptions were then abstracted and coded to enable interpretation of the underlying meaning. Next, the codes were sorted into inductively shaped sub-themes (Graneheim & Lundman, 2004). These sub-themes were amalgamated in a process of switching between the data and relevant literature on teamwork and interprofessional collaboration; three themes emerged. The themes thus represent constructions that transcend the boundaries of descriptive analysis. Table I presents an example of a meaning unit along with its condensed meaning unit, code, sub-theme, and theme.

The second phase of analysis was focused on further interpretation of learning situations. The critical incidents were explored on the basis of the sub-themes with respect to reports of joint discussions, and statements as to whether the situation had been resolved. The coding and sorting into sub-themes was discussed with a senior researcher in the field of health and social sciences, and adjustments were made. The relevance of the preliminary themes and sub-themes was then verified in a session with another local healthcare team, and further

Table I. Example of a meaning unit, along with its condensed meaning unit, code, sub-theme, and theme.

Meaning unit	Condensed meaning unit	Code	Sub-theme	Theme
There was little interest when I reported on [the patient case] to the team; the response was "is that so?"... The others yawn when I tell them what I encounter. (C:18:1)	Others show lack of interest in skills and experiences	Knowledge not valued equally	Not valued, not put to use	Knowledge contribution of the professions

adjustments were made. Prior to this session, the session participants had responded to the same team type survey (Thylefors et al., 2005) as the interviewees, and had described their team as being similar to the teams included in the study; hence, they could be assumed to be able to relate to and discuss the preliminary findings.

Findings

The study findings are presented in three sections: team characteristics; reported difficulties; and verbal actions and resolutions.

Team characteristics

All respondents perceived their teams as being mainly interprofessional or transprofessional. None identified their team as multiprofessional in accordance with the team type index developed by Thylefors et al. (2005). Some of the teams were permanent, while others were temporary groupings of members from a specific workplace. The members were mainly co-located. The respondents regarded their teams as having mainly patient treatment tasks. There was consensus among the participants from two of the teams that the team did not have a formally appointed manager, while the respondents from the two other teams varied in their perceptions of formal management.

Reported difficulties in interprofessional teamwork

Three themes emerged in the content analysis regarding perceived difficulties in connection with interprofessional teamwork: (A) the team dynamic; (B) the knowledge contribution of the professions; and (C) the influence of the surrounding organization. An account follows of various aspects found within these themes, which are based on a number of sub-themes.

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. There was a perceived demand to act as a team member in all situations, and when there disequilibria arose between what the *team decided* and *the individual's or professional group's decisions*, the situation was perceived as a critical incident. Individuals adapted, and partially relinquished their autonomy, in order to belong to the team. Being allocated *unequal responsibility*, whether for running the team's joint decision process, for motivating other participants to get involved, or in being the only person from a professional group to make judgements, was perceived as a difficulty. *Role boundary conflicts* were described when team members overstepped the boundaries of another individual's professional territory. One respondent reflected on the consequences that an incident had for her:

> It ends up with me getting . . . damn. I got a little irritated. So, damn it, whatever, you know. Everybody is doing my job. Or think they are doing my job. (sub-theme 3)

Another theme (sub-themes 4 – 6) comprised the team members' experiences of interactions among the knowledge bases of the various professions and skills in the team. The knowledge contribution of the individual's own profession was not always *valued equally or put to use*. The interviewees felt that not all team members were given the opportunity to contribute their views on the patient and their experiences from patient care meetings. When the other

team members demonstrated lack of interest, the individual was easily silenced. One respondent described the situation:

> There was little interest when I reported on [the patient case] to the team; the response was ''is that so?'' . . . The others yawn when I tell them what I encounter. (sub-theme 4)

Both those who believed they had been personally affected by this and those who described the situation from a majority position felt that the consequences were the same; the team's potential could not be fully exploited, and so the team could not adopt the expected holistic view of the patient's problems. *Lack of consensus* was reported as a difficulty when new and unknown skills were added to the team, but also as one that could arise in the absence of new team members. *Uneven distribution of current knowledge* was a reported difficulty that had to do with presence in the team. Unless everyone in the team had the same information and thus not the same current knowledge, they could not collaborate effectively, and dealing with the patient was considered more difficult.

The final theme (sub-themes 7 – 9) reflected the influence of the surrounding organization on the interprofessional approach. This theme was interrelated with the other two themes. Team members experienced difficulties when the organization had *hierarchical valuations* of the various professions that made it more difficult for individuals to feel like valued members of the team. *Changes in the organization and setting* over which the members had no control were primarily related to changes in team members, team size, increased patient inflow, and inadequate physical placement; the consequences were greater insecurity, silence, and an inconsistent sense of belonging. Situations in which *the team was not composed of the right professions* were reported as difficulties in the sense that the team lacked the resources to meet the patient's needs in the right way. One informant described an incident:

> I'm thinking about a lady now who is . . . alone and has no children and a great many questions and worries, and in that situation we might of course think that contact with a [profession] might help her . . . when it used to be easier to approach [profession], we could go and ask the patient, would it be OK for us to contact [profession] . . . and we had one in our team and then she could get in touch with the patient, so of course it was easier. (sub-theme 9)

The sub-themes and themes can be visualized using a diagram (Figure 1). Themes A and B are placed in an inner circle that symbolizes the team. Theme C is placed between the inner circle and the outer circle, where the latter illustrates the team's context. The lines are dashed to indicate permeability.

Verbal actions and resolutions

Figure 2 divides the reported difficulties (sub-themes) according to whether or not they were managed via joint discussions, and whether or not the difficulties were perceived as having been resolved. The division is portrayed as a matrix; one axis shows ''Discussion among the entire team'' versus ''No discussion among the entire team'', while the other axis shows ''Resolved'' versus ''Not resolved''. The matrix thus has four fields.

Field 1 contains sub-themes representing difficulties that were jointly discussed within the team and which were perceived to have 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. These dilemmas were

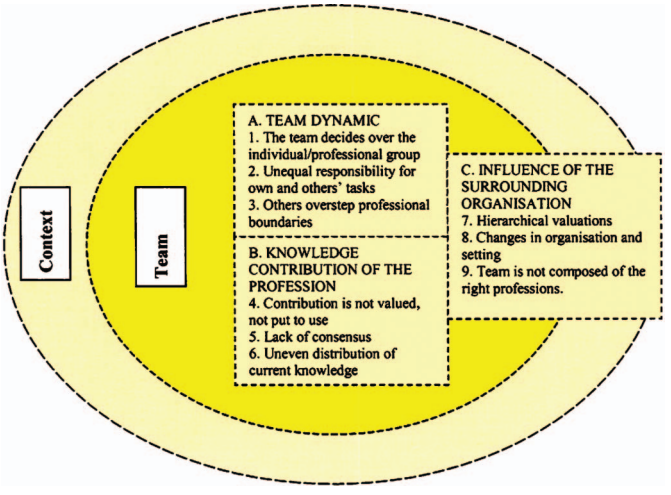

Figure 1. Reported difficulties experienced by team members ($n = 18$) in interprofessional teamwork. Themes (A – C) and sub-themes (1 – 9).

	Resolved	Not resolved
Discussion among the entire team	*1. Discussion, resolution* Uneven distribution of current knowledge Team are not composed of the right professions. ("second-best solution") Lack of consensus (situations involving differences in judgement)	*2. Discussion, no resolution* Unequal responsibility for own and others' tasks Changes in organization and setting
No discussion among the entire team	*3. No discussion, resolution* Team decides over the individual/occupational group Others overstep professional boundaries Lack of consensus (situations involving lack of coordination)	*4. No discussion, no resolution* Contribution not valued, not put to use (rarely discussion among the entire team) Organization's hierarchical values influence the team

Figure 2. 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 appears in two fields.

perceived as having reached a favourable resolution, or at least a "second-best solution". When the team *was not composed of the right professions*, the joint team strategy was described as identifying "second-best solutions". *Lack of consensus* was managed both with and

without common dialogue, and hence appears both in this field and in field 3. Here, situations involving differences of judgement between two members could be managed by using the rest of the team as a resource. One respondent described the process as follows:

> [The question is:] How you should [treatment], what is best to [treatment] at that particular moment . . . if you have somewhat different opinions, you bring in other professions so that it is not just the two of you, and instead you bring in more professional categories so that you can gather round this patient and discuss other . . . and of course that makes it easier to arrive at a solution, if you have more people giving their opinions. (sub-theme 5).

Field 2 contains sub-themes representing difficulties that were jointly discussed, but which were not perceived as having been resolved. Team members believed that *unequal responsibility for their own and others' tasks* could be dealt with through joint communication within the team, although the difficulties were rarely resolved. Respondents believed that situations caused by *changes in organization and setting* could be talked about jointly, and they described how team members had managed the difficulties on in-service training days and other similar situations.

Field 3 contains sub-themes representing difficulties that were perceived as having been resolved without joint discussions. When the difficulties were of the type such that *the team decides over the individual/professional group*, the problems were described as being managed by the individual, or with the support of a third person, rather than being addressed by the entire team. Situations where *team members overstepped the boundaries of another individual's professional territory* were managed by the individuals involved, whether by resisting, by preventing the situation, or by attempting to identify ''second-best solutions''. Difficulties related to *lack of consensus*, in terms of appearing coordinated in front of the patient, often resolved themselves with time, without joint discussions in the team.

Field 4 contains sub-themes representing difficulties that were not jointly discussed and were not perceived as having been resolved. Management of situations in which *the knowledge contribution was not valued or put to use* usually had a personal dimension. Those who experienced the situation from their own perspectives believed that the responsibility for solving the problem lay with the individual. One respondent described the situation:

> It *is* like that, we have meetings and of course it's the multiprofessional team sitting there, that's clear, that is just the way it *is*, that is the culture. And of course it may be that I am thinking of [professional group] especially, which has this [area of expertise], and I think we have to in some way assert our own worth among ourselves, emphasise that we also have an important role, important viewpoints, and then they pay attention for a while and then things go back to the way they were. (sub-theme 4).

In one case, the team members felt that the situation was managed jointly and that they had arrived at a good resolution. In other cases, although wishes were expressed for the team to discuss the dilemma, the issues were sensitive and the problems were rarely resolved. The team members rarely believed that the *organization's hierarchical valuations* could be managed jointly, and no resolutions were reached in these situations either.

Discussion

This study identifies and describes health professionals' perceptions of difficulties in connection with interprofessional teamwork. From a sociology-of-professions approach, the

team members' experiences of team dynamics may be represented as the dynamic between professional and interprofessional agendas. This study's findings confirm the results of earlier studies at community health centres and intensive care units. These studies, conducted in a Canadian context, show that individual ownership of the profession is the basis for negotiations during interprofessional interactions and that there is tension between disciplinary logic and interdisciplinary logic (Sicotte et al., 2002; Lingard et al., 2004). When other team members overstep the boundaries of their professional roles, this tension creates defensiveness, a phenomenon that has also been described in studies by Jones (2006) and Long et al. (2003).

The results in this study regarding difficulties related to the contribution of professional knowledge bases are in concordance with studies showing that team members often do not acknowledge, do not understand, or do not respect each other's roles and knowledge contributions (Elwyn et al., 2002; Long et al., 2003; Larkin & Callaghan, 2005). This can also be viewed in terms of the sociology of professions; the varied status of the professions may have an impact on how and whether knowledge contributions are put to use. The present study adds to the contributions of the studies cited above in that it also identifies, in addition to the individual consequences, the perceived consequences for the team: losing the holistic view, lacking consensus, and being unable to present a united front to the patient. Using terminology taken from task-oriented management theory, the team in such situations could most accurately be regarded as a pseudo team according to Katzenbach and Smith (1994). The notion of pseudo team indicates that the team was not sufficiently focused on the collective performance and was not considered capable of providing effective care based on a multifaceted view of the patient's problem.

It is not entirely unusual for collaborative ability and teamwork to be developed without tangible support from the organization (Pritchard, 1995; Beyerlein et al., 2004), and changes are often made to a team organization with no insight into how teamwork differs from a traditional bureaucratic working model (Turniansky & Hare, 1998). This study demonstrates that the sense of belonging and collaboration was influenced both by valuations of the status of the professions that were transferred from the organization and by changes made to the team organization about which the team itself had no say. An American case study of integrated teams in primary care by Cashman et al. (2004) showed that organizational structures and incentive schemes must be linked if efficient team function is to be maintained. The significance of the organization to teamwork is further confirmed in a Swedish study, which concludes that the organizational framework has separated care providers in primary care teams from policy-makers; and that, as a result, healthcare policy does not correspond to available resources (Timpka, 2000). The capacity to identify and compose professions and skills in the team is crucial to dealing effectively with the patient's problem (Øvretveit, 1997; Drinka & Clark, 2000; Hornby & Atkins, 2000). However, the present study indicates that management at the level above the team had some weaknesses in allocating optimal resources to the team to allow it to exercise this essential team skill, and thus in providing the prerequisites for the team to perform its tasks in the manner believed best.

Implications for interprofessional learning in teams

This study explored utterances on verbal actions taken in connection with difficulties in interprofessional collaboration, and the respondents' perceptions of whether these difficulties could be resolved. The intent was to enable discussion of the implications for interprofessional learning in teams. This discussion is based on two points of departure;

first, that involvement in interprofessional teamwork entails experience-based lifelong learning for the professional (Drinka & Clark, 2000), and second, that experiences of managing difficulties are learning opportunities. A supplementary picture including four different learning situations emerged through analysis of the previously discussed matrix (Figure 2) from a learning perspective. The learning situations were dependent on whether or not the difficulties were perceived as having been managed in joint discussions (reflection and planning), and whether or not they were seen as having been resolved (action and experience). The following argument is based on the assumption that all four situations provided potential for interprofessional learning, but of different types.

Situations involving both joint conversation and resolution are included in field 1. One interpretation of these situations is that difficulties which were discussed by the entire team, and which were believed to have been resolved, could constitute a source of positive group learning. This learning may be described as a complete action-cum-learning cycle (Ellström et al., 2000), and as such could also reinforce the team's interprofessional work. The situations (field 2) in which all professional groups talked about the difficulties together without arriving at a resolution may be perceived as having constituted an inwardly-directed uniting force for the team members, but could also have involved learning that the team's drive and goal attainment were weak.

The two remaining fields concern difficulties about which the team rarely talked as a group. Interprofessional learning in the team was obstructed because the experiences were seldom dealt with in joint reflection, and so had little potential for leading to joint action and experiences. In situations (field 3) where the difficulties were not discussed but were nevertheless resolved, the learning may be described in such terms that the individuals had learnt that certain things are better handled interpersonally, and that the team was not suitable for use as a common resource. It can be concluded that the potential for empowering interprofessional team learning was lowest in situations that were rarely managed in joint talk and were not resolved (field 4). This field encompassed certain dimensions of the organization's hierarchical valuations, and the perception that the knowledge contribution of one of more professions was not valued or put to use. A conceivable interpretation is that team members learned that these situations were not amenable to joint reflection by all professional groups, and that they could not expect these difficulties to be resolved.

These findings may have implications for practice both 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 the team manage in joint discussions? What aspects are found in the team's ''field 3'' and ''field 4''? Are these fields most appropriately managed individually, in sub-groups, or jointly? Are there any advantages or drawbacks to bringing up the issues in joint conversation? How might these strategies affect the team's interprofessional learning and teamwork? It should be noted that the team members' sense of security should be taken into consideration in relation to such group reflectiveness.

Methodological considerations

The concept of credibility in qualitative content analysis is concerned with aspects such as choice of study focus, participants, and data collection approach (Graneheim & Lundman, 2004). The informants were selected from all professions present in the team in order to gain rich variation of the studied phenomenon. The participants were expected to have experience with difficulties in interprofessional teamwork, both by restricting the selection to individuals with more than one year's team experience and through the descriptions of team

types arrived at via the survey responses. Scott Poole and Real (2003) assert that the design of team studies often lacks adequate description of team characteristics, which prevents the researcher from considering the impact of the team dynamic on the findings. The participants' descriptions of their teams in the survey also compensated for this common weakness in the design of team studies.

The choice to use Critical Incident Technique (CIT) entailed findings that in large part correlated with studies conducted using other data collection techniques, which both establishes the usefulness of the approach and puts it on an equal footing with others. Compared to other techniques, however, CIT also produced expanded data on the consequences and management of difficulties, which enabled further analysis and thus contributed to deeper understanding of interprofessional collaboration.

Conclusion

The findings of the study reported here show that the perceived consequences of difficulties included, firstly, restriction on the use of collaborative resources to arrive at a holistic view of the patient's problem and, secondly, the inability to provide patient care and service in the way that team members would have liked. This indicates that the study participants, in addition to expressing individual experiences of frustration, related the difficulties to a 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.

The study also shows that the team members had developed strategies for managing and attempting to resolve difficulties. These strategies involved various forms of interprofessional learning, that is, learning that arose through interaction between the professions. The implications for learning varied depending on whether the difficulties were managed in open joint discussions or not.

Finally, the study shows that members of collaborative teams do not always perceive themselves as having the support of the organization, which stresses the importance of implementation processes. One conclusion is that managers who (entirely legitimately) demand results from their interprofessional teams should also include an assessment of existing organizational conditions to enable an organizational learning.

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