Good health for all: an ethnographic study of frontline professionals in general and mental healthcare and social welfare

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Chapter 4

Interprofessional collaboration in fluid teams: An ethnographic study in a Dutch healthcare context

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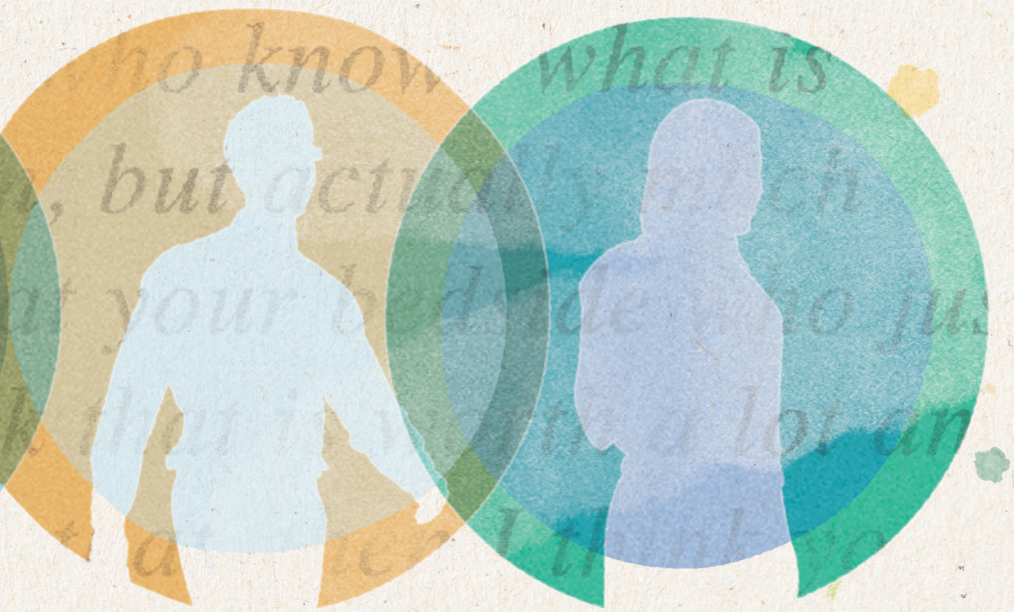

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Abstract

In caring for clients with combined problems, various professionals are encouraged to work together in new ways. Collaboration is often fluid, and professionals are expected to seek other professionals and organizations to solve combined problems. This type of collaboration is not institutionalized; it may therefore be hard to develop routines compared to fixed teams. Knowledge about how frontline professionals work together in non-institutionalized forms of fluid collaboration is lacking. This article addresses this gap by studying how professionals from various disciplines work together in fluid collaborative contexts when caring for clients with combined problems. To this end, this empirical research has an iterative design and uses ethnographic fieldwork in studying these hard-to-grasp contexts. In the analysis, we explore whether and how interprofessional collaboration manifests in fluid teams in general practice, mental healthcare and social welfare a Dutch city and how team fluidity plays a role.

4.1 Introduction

When providing care for clients whose problems cross domains, and due to the growing complexity of problems in today's context more generally, professionals from various disciplines are increasingly collaborating to achieve their goals (Edmondson & Harvey, 2018). This trend is on the rise as diverse groups, from various functions, organizations, and sectors unite to address combined challenges in rapidly changing configurations (Kerrissey et al., 2020). The added value of interprofessional collaboration is now widely recognized and a significant amount of research has been conducted on this topic (Petrakou, 2009; Schot et al., 2020; Wei et al., 2022). Regardless of the value of this research, it primarily pertains to fixed teams. Traditional or fixed teams have binary team membership, based on either belonging or not belonging to a team with clear boundaries (Mortensen & Haas, 2018), meaning that their membership is stable. However, the composition of teams is often subject to change (Kerrissey et al., 2020), meaning that cross-boundary collaborative work is characterized by variation and constant change over time (Dow et al., 2017; Morgan et al., 2015; Schot et al., 2020). Moreover, the nature of the issues they work with leads professionals to work interdependently, because it may be unclear who may be required and at what point they may be needed to do the work (Kerrissey, 2018). This paper focuses on interprofessional collaboration in psychosocial care which is often characterized by such team fluidity.

Following Kerrissey and Satterstrom (2020), team fluidity means that teams have a high degree of change and difference in terms of membership. Understanding team fluidity in healthcare is important because it may give insight into how care is changing from fixed to fluid teams, which can aid in fostering improved interprofessional collaboration among professionals (Wei et al., 2022). This paper therefore explores how team fluidity plays a role in interprofessional collaboration in care. The research question is as follows: *What does interprofessional collaboration look like in a fluid team context?* To answer this question, an ethnographic research design was used. We selected teams that are characterized by fluidity and thus in which frontline professionals have to interact and coordinate their work with other professionals with varying forms of membership and differences between members. The methods used are participant observations and interviews and the respondents are frontline professionals from social welfare and general and mental healthcare. These professionals all work with clients with combined psychosocial problems. This context enables us to answer this research question, because these respondents by definition have to collaborate across professional and organizational boundaries to care for their clients.

This study contributes to the existing scholarship in two ways. First, literature on interprofessional collaboration in care does not address team fluidity (Schot et al., 2020; Williamson et al., 2012; Xyrichis & Lowton, 2008), while fluid teams exhibit distinct charac-

teristics that may play a role in how interprofessional collaboration takes shape (Bagayogo et al., 2016; Dow et al., 2017; Schot et al., 2020). Our research therefore contributes to the knowledge base on interprofessional collaboration in care as we explore how behaviors in interprofessional collaboration are potentially shaped by team fluidity, using the analytical framework as developed by Kerrissey et al. (2020) and Edmondson and Harvey (2018).

Second, while literature on teamwork in management science takes a solid initial step in conceptualizing and empirically studying fluid teams (Kerrissey et al., 2020), it predominantly relies on data about hospitals (e.g. Valentine & Edmondson, 2015) and ad hoc disaster response teams (Rashid et al., 2013). Our study contributes by examining how team fluidity plays a role in the context of frontline professionals in psychosocial care. This is relevant because, while in hospitals, professionals work in fluid teams for delineated tasks such specific operations with fluid personnel (Kerrissey et al., 2020; Rashid et al., 2013; Valentine & Edmondson, 2015), in psychosocial care, frontline professionals structurally work in fluid teams.

In what follows, this article conceptualizes team fluidity and interprofessional collaboration, by relying on literature on team fluidity in management sciences and interprofessional collaboration in care, it describes the study context, and the study design, before presenting and discussing the empirical findings.

4.2 Conceptualizing team fluidity and interprofessional collaboration

In this analytical framework, we draw a connection between team fluidity and behaviors in interprofessional care.

Team fluidity

This paper addresses team fluidity based on its characteristics outlined by Kerrissey (2018), which refers to new adaptive and dynamic forms of collaboration characterized by high levels of change and difference (Edmondson & Harvey, 2017; Kerrissey et al., 2020). Team fluidity is continuous, recognizing that individuals can participate in a team to varying degrees, at varying times, with varying other participants, and in varying roles (Mortensen & Haas, 2018). Following Kerrissey and colleagues (2020), factors of change or temporal instability arise in teams facing complexity due to the need to accommodate emerging demands, which makes anticipating required roles difficult. '*These teams shift their membership, change their goals and tasks, rapidly form or disband, or interact infrequently over long time periods* (Kerrissey, Satterstrom et al. 2020).' Furthermore, individual and situational difference in teams are increasingly evident in complex work context. These contexts are more diverse because combined challenges cannot be solved by a single organization (Alexander and Van Knippenberg 2014, Kerrissey, Satterstrom et al. 2020).

First, '*change*' means the dynamic evolution of team membership over time (ibid., 2020, p. 64). With membership changes, aspects such as goals and tasks automatically also change (ibid.). As such, the composition of the team may change frequently as individuals join to contribute their expertise and leave when their role is completed (Edmondson, 2012; Matthews et al., 2012; Mortensen & Haas, 2018). For example, temporary teams in hospitals fall into this category (Valentine & Edmondson, 2015). Second, '*difference*' refers to individual and situational disparities among individuals working together. With membership differences, aspects such as skills, language, culture and geographical locations also differ (Kerrissey et al., 2020; Mortensen & Haas, 2018), such as in situations when combined challenges have to be solved (Edmondson & Harvey, 2017). Teams with high levels of change and difference are thus called fluid teams (Gersick, 1988; Kerrissey et al., 2020).

Interprofessional collaboration

In this study, interprofessional collaboration is defined as an active and ongoing partnership between people from diverse professional backgrounds with distinctive professional cultures and possibly representing different organizations or sectors, who work together to solve problems or provide services (Morgan et al., 2015; Schot et al., 2020). Research often sees interprofessional collaboration, where various frontline professionals work together to care for clients, as contributing to good care (Bosch & Mansell, 2015). Based on a systematic review, Schot and colleagues (2020) identified three distinct behaviors essential to interprofessional collaboration in care: creating spaces, bridging gaps, negotiating overlaps. In what follows, this section will discuss these.

Creating spaces

Following Schot and colleagues (2020), the first behavior in interprofessional collaboration, *creating spaces*, is necessary for interaction in collaboration. Creating spaces holds that professionals establish spaces for interaction with external stakeholders (Nugus & Forero, 2011), by creating or recreating organizational arrangements to facilitate collaboration, and by circumventing existing organizational structures and establishing alternative, informal channels of information exchange (Gilardi et al., 2014). It is linked to the concept of organizing, which includes professionals organizing case treatment through interprofessional collaboration and fostering innovation rather than just treating patients within a healthcare organization (Noordegraaf, 2015). Creating spaces also resembles articulation work (Postma et al., 2015) and knot working (Lingard et al., 2012) in healthcare, which mean integrating tasks, responsibilities, and improvisation to negotiate everyday challenges.

Bridging gaps

The second behavior, *bridging gaps,* involves professionals actively overcoming four distinct types of gaps that exist between themselves and other professionals. The initial gap arises from varying *professional perspectives* on the optimal approach to client treatment. Bridging thus requires proactive efforts to familiarize oneself with the knowledge bases, professional values, and norms of other professionals (Chreim et al., 2013; Falk et al., 2017). The second gap involves professionals addressing *social gaps*. This pertains to informal and tactful interaction that considers the diverse personalities of individuals. Third, professionals bridge *communication divides* caused primarily by geographical fragmentation. Bridging, in this context, entails actively transferring knowledge or information between professionals and being accessible to others (Schot et al., 2020). Fourth, professionals bridge gaps related to *task division* by undertaking responsibilities that extend beyond their formal roles and provide assistance to other professionals (ibid., 2020). This concept is associated with boundary spanning, which refers to key agents managing interorganizational collaboration, interpersonal relationships and networks, creating innovative solutions and having knowledge of various cultures acquired through listening and understanding various professionals' positions and interests (Bakken & van der Wel, 2022; Williams, 2002).

Negotiating overlaps

The third behavior, negotiating overlaps, involves managing the overlapping aspects of professional work that arise due to collaborative demands that can potentially lead to conflicts. First, professionals negotiate between work roles and responsibilities in general, as collaboration can create ambiguous overlaps in determining tasks and responsibilities (Lingard et al., 2012; Schot et al., 2020). Second, professionals engage in negotiating overlaps within individual care processes, particularly when they collaborate in patient treatment, leading to the identification of noticeable overlaps (Schot et al., 2020). Member role clarity is considered important for interprofessional collaboration (Barnard et al., 2020; Wei et al., 2022), because, while in some organizations, membership changes induce creative ideas, for most organizations membership changes could be problematic if they threaten members' sense of belonging and trust (Cristancho et al., 2022; Mortensen & Haas, 2018).

Our general expectation is that professionals in fluid team contexts will experience tensions in interprofessional collaboration due to change and difference, because professionals with various backgrounds meet each other more on an ad hoc basis and collaboration is based on fragile interpersonal relationships.

4.2 Data and methods

Research design and data collection

This article is based on data from an ethnographic study including participant observation and interviews. The role of the participant observer was taken with varying degrees of participation, requiring the researcher to be flexible and responsive to respondents' signals (Bernard 2017). The approach adopted in this article is abductive (Schwartz-Shea & Yanow, 2013), which combines induction and deduction. The study uses theoretical insights on team fluidity and interprofessional collaboration in care as sensitizing concepts to steer the fieldwork and analysis, while still allowing for inductive findings and adjustments (Schwartz-Shea & Yanow, 2013). The sensitizing concepts in this study are behaviors in interprofessional collaboration (Schot et al., 2020) and change and difference (Kerrissey and colleagues, 2020), which holds that these concepts are sensitizing rather than definitive, because they lack specification of attributes or benchmarks that would allow for clean-cut identification in the context of interprofessional collaboration in care (Blumer 2017). Specifically, how change and difference play a role in behaviors in interprofessional care is unknown; which is inductive, regardless. Despite what we know of change and difference in other contexts, we thus recognize that these concepts may shape up in different ways in each empirical context. This qualitative research expands the literature by including different professional disciplines working with the same client group (Schot et al., 2020). Qualitative approaches over extended time periods are suitable to answer our research question, because a new phenomenon like interprofessional collaboration in a fluid context may change quickly and ad hoc and may not be prearranged (Edmondson & McManus, 2007; Kerrissey et al., 2020). Ethnographic fieldwork thus provides broader and more flexible approaches to collecting data that are advantageous in achieving a deeper understanding of fluid teams (Kerrissey et al., 2020; Kolbe & Boos, 2019).

The observational data consists of three months or 150 hours of observations of interactions between frontline professionals in psychosocial care and other frontline professionals who are part of the team, their clients and others involved in the care process. During observations, the researcher was allowed to be present during patient consultations, in lunch rooms, in professionals' offices and during collaborative meetings. To give insight into how respondents reflect on what the first author had observed, follow-up questions were asked during many informal conversations and three formal interviews during the fieldwork. The data generated through participant observation were written down as field notes (Spradley, 2016). During observations, interest was taken in how professionals behave in interprofessional collaboration in fluid teams. Two rounds of observations were performed, with preliminary analysis in between. After three months per research site, the researchers noticed that the same themes were recurring (saturation). Then, the first author conducted three more formal interviews to

check and reflect on what was observed (see observation guide and interview guide in appendix C1 and C2). The authors use triangulation by drawing on data generated with multiple methods (interviews and observations), which helped to increase our ability to interpret interprofessional collaboration in fluid teams (Thurmond, 2001). This study was registered and approved by the Medical Ethical Review Committee of Leiden, The Hague and Delft (N20.158).

Research setting and implication

The empirical study includes six main respondents in three professional groups who bear responsibility for clients with psychosocial problems. Respondents were selected on theoretical grounds: the professionals all work in fluid teams in social welfare, mental healthcare or general healthcare. Professionals have to collaborate across professional domains, because their clients' problems cannot be solved within one domain. Within this sample, a convenience sampling strategy is used, which means that we included who wanted to take part in the research and who was available.

The Dutch healthcare system emphasizes a broad view of health and care, acknowledging the interaction between physical, mental, and social health. This approach, combined with focus on patient-centered care that caters to individual needs and integrated care around people with combined problems, reinforces the necessity for frontline professionals to work on various health aspects and in various team settings (Standaarden n.d., Ministerie van Volksgezondheid 2016). In the Netherlands, the trajectory of a client with psychosocial problems always begins with the general practitioner (GP) who possibly collaborates with various types of organizations through referrals and other types of contact. Professionals in these organizations are working in general healthcare, social welfare, mental healthcare and beyond. Therefore, professionals working with the same clients do not always work within the same organization and may have different objectives. As a result, the teams they work in are dynamic, and there can be differences among the included professionals.

A fluid team is defined as a new and dynamic form of collaboration characterized by high levels of change and difference (Kerrissey et al., 2020). High levels of change create entitativity challenges concerning data collection, which means that it is harder to know whom to count and when to observe (Kerrissey et al., 2020). The functioning and character of the team, including their goals and tasks, may change over time (Tannenbaum et al., 2012). Considering these challenges related to team definition, the authors opted to study six main respondents. Each of the main respondents and those stakeholders they interact with to care for a client are considered part of the team. The main respondents remain on the team, while other professionals and stakeholders may shift on and off the team. The lead author consistently shadowed the respondents' interactions focused on promoting the health of shared clients. To be able to interpret

interprofessional collaboration and to get a grip on what team fluidity looks like, the first author used follow-up questions as a means of reflection and contextualization.

Analysis

The analysis took place in Atlas.ti. The lead author first selected data excerpts related to interprofessional collaboration as defined above. Second, during focused coding, the lead author confronted the data excerpts with the sensitizing concepts (change and difference) to explore how respondents collaborate interprofessionally in fluid teams and how team fluidity plays a role. Our approach thus involves examining whether we observe interprofessional collaboration, if so in what form, and finally identifying any additional elements compared to the analytical framework. Constant comparison between and within teams has been central in our analysis, as have member checking and searching for alternative explanations (Braun & Clarke, 2006; Schwartz-Shea & Yanow, 2013).

4.4 Results

This section outlines how professionals operate and talk about interprofessional collaboration in a fluid team. Examples are based on the empirical data, with references made in italics to the theoretical framework. The paragraph structure aligns with the seven behaviors in table 4.1, including reflections on the interprofessional care literature and on team member change and difference. Empirical findings are summarized in table 4.1.

Interprofessional collaboration in a fluid team context

Creating spaces

Creating alternative communication lines

Respondents create alternative communication lines in between professional domains in order to *bridge knowledge* gaps and partner matching gaps (see next sub-section). Respondents create new ways to discuss cases and exchange information that go beyond professionals' expertise and/or role.

Respondents create communication lines by inventing new positions within an organization or by temporarily inviting professionals from another professional domain to gain a grip on what their clients may need from other professionals, which is illustrated below.

> ***'But luckily we have […] [our practice assistant]*** (fieldnote, RA, general healthcare)'
>
> 'Respondent A explains that they are lucky to have this new practice assistant, who works on maintenance psychiatry, who knows everything about psychosocial care and '*the social domain is quite complicated to oversee, it changes all the time. But […] I use her expertise [to gain a better understanding of the social domain] when I want to have a quick discussion, or I [ask her to have] a conversation with that patient*'.

With the *creation* of this new type of general practice nurse practitioner, general practitioners (GPs) create an alternative connection with professionals in and knowledge of social welfare and mental healthcare. This guides respondents in identifying collaboration partners and managing workload by delegating tasks to practice nurses. This finding adds to the work by Schot and colleagues (2020), who emphasize connections with external actors but do not delve into intermediary roles created to connect internal and external actors across domains. Respondent A's team is characterized by membership change in various ways. First, the position of the new nurse practitioner is fragile due to insecurity about sustainable funding. Second, our data show that frequent changes in the social welfare domain regarding who works in which position are challenging, especially when respondents do not oversee the different frontline professionals in other domains. Membership change creates tensions in terms of who to reach and how to reach them, necessitating the creation of alternative communication lines as respondents cannot depend on fixed ones.

Organizing valued spaces

To assess individuals' contribution to a team, respondents arrange both structured and ad hoc formal meetings, inviting professionals from various domains. This effort helps professionals in coordinating mutual introductions and understanding each professional's role in relation to the client.

> ***'[We want to know] what she can mean for us and our [clients]***
> (fieldnote RE, social welfare).'
>
> 'After discussing several cases, the professional said that they invited a professional '*from "safe at home" [to get acquainted and] to have her explain a bit about her goals and tasks and to discuss what she can mean for us and our [clients].* The meeting ended with the exchange of phone numbers.'

By organizing biweekly interprofessional meetings, GPs regularly invite professionals from social, general and mental healthcare. In this example, they extended an invitation to someone from another organization for an introduction. This form of acquaintance during formal meetings allows professionals to collaborate more informally when necessary. Through such meetings, professionals aim to explore mutual offerings, understand each other's roles, and comprehend individual values.

More actual organizing or coordinating is required in a fluid team context, compared to what is mentioned in the interprofessional care literature (Nugus & Forero, 2011; Schot et al., 2020) on professionals creating spaces in relation to external actors. In our data, professionals not only create spaces to approach other professionals, but also create spaces to find out who to potentially reach, how to reach them in physically distant organizations and how to facilitate valuable collaboration. Respondent E's team is characterized by membership change. Which professionals are present at meetings changes, depending on who is invited to the meetings and who are acquainted with one another. What is challenging, according to respondent E, is that they cannot depend on those who are already acquainted. Respondents therefore invite other professionals to team meetings to find out who would be valuable to the team. Moreover, this team is characterized by membership difference, because professionals are often in the dark about each other's similarities or differences before meeting one another. Respondents manage membership changes and differences by organizing valued spaces. However, it can be challenging to determine who to invite or not to invite to team meetings, which sometimes results in potentially relevant professionals being left out (fieldnote RE).

While both creating alternative communication lines and organizing valued spaces appear highly formalized, our study aligns with Schot and colleagues (2020) in highlighting that much of the space creation is based on informal personal relationships. Notably, our study emphasizes that professionals often dedicate their personal time to creating these spaces, rendering them fragile and potentially less sustainable.

Bridging gaps

Bridging knowledge gaps

Frontline professionals bridge *knowledge gaps* with external actors, complementing each other's expertise to enhance client care in fluid teams. Respondents thus get a grip on the problem by leveraging differences in professionals' expertise within and between organizations. Respondent D, a mental healthcare worker, clarifies the client's needs to a municipal worker to safeguard the client, addressing concerns regarding the latter's overly positive perception.

'***I make sure that the municipal worker has the right knowledge*** (fieldnote RD).'

'Respondent D has an appointment with a client and a municipal worker in order to assess the eligibility for benefits. The respondent explains that she first invites the client for a preliminary discussion before adding the municipal worker. She calls the client and says that the municipal worker wants to ask her questions and that he has to give consent. Then she explains what she may and may not tell the municipal worker and asks if that's okay with him. The client agrees and the respondent adds the municipal worker. [...] The municipal worker says that she wants information on his phobia and what considerations she should take into account regarding the activities he can undertake as a counterpart for his benefits. [...] After the respondent explains the client's disorders, the municipal worker says that she will now explore how work can contribute to his recovery [...]. The respondent emphasizes the importance of proceeding cautiously in small steps and being critical of the environment for the client's long-term wellbeing. The client acknowledges this, expressing appreciation for her remarks. The municipal worker affirms that it is therefore crucial that they have this conversation.'

The respondent calls the municipal worker to make sure that she has the necessary mental healthcare knowledge to properly decide on the vulnerable client's case.

Similar to an emphasis on establishing a common narrative between *professional perspectives* within fixed teams, as suggested by a review of the literature on interprofessional care (Schot et al., 2020), our respondents reconcile diverse professional perspectives on client treatment by complementing each other's knowledge. Thereby, respondents seek the best way to treat clients. Nevertheless, our respondents actively seek diverse perspectives to better assist clients, not just overcoming gaps in professional perspectives. Respondent D's team shows membership differences, creating varied mental healthcare knowledge among professionals. Professionals leverage different professionals' background to their advantage by complementing each other. Additionally, the changing composition of the team per problem further plays a role, because familiarity aids in bridging knowledge gaps (RD).

Bridging communication gaps

Professionals bridge *communication gaps* by leaving notes for colleagues whom they do not see due to different work schedules and/or different physical workplaces. The following fieldnotes show how professionals do so within and between organizations.

Respondent E explains that she never sees '*the assistant, because [their] working hours don't correspond. This issue really needs to be caught up on, so I'll leave a note for her.*' Moreover, respondent C explains that she puts a note under the door of the professional responsible for the day program in a nearby organization. In this way she lets her know without speaking to her directly that the client still needs to get his medicine. The examples show how differences in work schedules, routines and workplaces necessitate the bridging of communication gaps by leaving notes for each other.

Our analysis shows that communication gaps are not solely caused by geographical dispersion, as suggested by Schot and colleagues (2020). Member differences, especially in work routines, also contribute when professionals lack physical collaboration opportunities. Bridging communication gaps thus involves collaboration among professionals with different professions, work schedules and work locations. When reaching out to professionals from other organizations becomes challenging, additional effort or creative strategies may be necessary to establish personal contact.

Bridging partner matching gaps

For different problem aspects, respondents turn to professionals in various organizations to identify the appropriate professional for client assistance, when they perceive their own capacity to help a client is insufficient. The gap holds that it is not consistently evident from the outset which professional they should ask for assistance. The following fieldnote shows how respondents bridge partner matching gaps:

> ***'[I try] to match the right partner*** (RF, mental healthcare).'
>
> '*To find the right partner and to do my job, I need a good social map. I depend on my network, especially in the neighborhood. I need good connections for smooth care. Given our large caseload, it also entails a lot of forwarding cases, organizing, facilitating access to, involving organizations, instead of handling all of that care provision oneself. It's simply quickly identifying what the problem is, and then matching it with the right partner. […] When I want to involve a partner, I try to be present in the neighborhood to become a familiar face. Sometimes I need to convince them that we have a shared interest in assisting the client. For example, with the housing association, I had to convince them that right now focusing of wellbeing is in the best of everybody's interest.'*

Respondents thus actively work to bridge partner matching gaps by going into a neighborhood to strengthen and engage their social network. In addition, they seek to convince other professionals of the mutual interests of collaborating with them to care for a client. Bridging partner matching in this fluid context differs from bridging

task division gaps in the interprofessional care literature (Schot et al., 2020). Unlike task division gaps, it involves actively seeking others to undertake tasks respondents cannot fulfill themselves. Respondent F's team is characterized by membership change and difference. In terms of membership change, the respondent has to change which professional or organization they engage with per problem aspect to temporarily join his team. Moreover, membership difference plays a role, as respondents contact professionals in different organizations and with different professions to help care for a client. As this section shows, respondents put in much work to find and match the right professionals for different tasks.

Negotiating overlaps

Negotiating responsibility overlaps

Frontline professionals negotiate overlaps between work roles when collaborating with professionals with their own focus and tasks, but where there is considerable overlap. While most respondents experience '*respect for each person's roles because we stand with our feet in the same clay*' (RF, mental healthcare), they find negotiating overlaps challenging when collaborating with professionals from external organizations. This is illustrated in the following interview excerpt from respondent A (general healthcare).

> ***'Getting angry doesn't help.'***
>
> *'I had to visit a man with a severe illness. Well, there's a nurse there who is terribly concerned and wants me to do all sorts of things, not trusting my knowledge and skills. I explain the situation, but she insists it's different and discusses it with the family and the patient without involving me, while I know that I'm right. She's a less educated lady [...]. How do you deal with that? [...] Getting angry doesn't help. At some point I said 'Now it's enough', this is how it is and if it doesn't improve, I'll come back another time. I was called back, went there again, and nothing had changed. [...] Then we got into a 'yes, no' discussion and it doesn't make sense getting upset about it nor calling her supervisor or something. What I could do is to notify the family next time. [...] But well, the family deals with that caregiver every day, and with me only once every three, four weeks, so it's an unequal situation.'*

In this example, both professionals think they know best and want to take responsibility for the client. While professionally, the GP may have authority, the nurse creates authority by being there for the client and their family very intensively. The respondent experiences difficulty negotiating taking back some authority and professional status.

Professionals thus experience tension when they negotiate overlapping roles and responsibilities to make sure that their clients are cared for properly.

Similar to a review of the literature on interprofessional care (Schot et al., 2020), our data show that collaborating can lead to unclear responsibilities (Lingard et al., 2012; Nugus & Forero, 2011). In contrast to this literature, our research in a fluid team context highlights these tensions. Respondent A's team is characterized by membership differences concerning professional background, physical work location and closeness to the client environment. These differences intensify the need for negotiating professional roles and responsibilities. Furthermore, membership changes, as highlighted by respondent F in mental healthcare, contribute to the challenge. High turnover and changing team composition make it increasingly challenging to identify appropriate partners for negotiations.

Negotiating safe work environments

Professionals negotiate who is admitted to the team and when to establish a safe work environment. The subsequent fieldnote from respondent F (mental healthcare) illustrates how professionals accomplish this.

> ***'It would be weird to have them listen in on how we work.'***
>
> '*Involving people from [another organization] to join our team meetings once a week is [...] important, because we need their input in difficult cases and we need to be able to rely on them. What is difficult, though, is that we already have too little office space and [...]*' the respondent's colleague adds that: '*it would be weird to have them listen in on how we work in all our cases, instead of those they are actually working on. We agreed that they only join when we talk about cases in which they are directly involved.*'

By negotiating, professionals agree on the attendance at team meetings. Through this negotiation, professionals aim to get to know each other slowly, rather than abruptly as it has been organized by their superiors. By doing this, they aim to protect themselves and their clients. Such negotiations are different from the types described in the interprofessional care literature (Schot et al., 2020). Professionals not only negotiate overlaps between work roles and responsibilities, but they also negotiate who may be part of the team and when. Respondent F's team is characterized by membership change, because the arrival of new members creates the need to negotiate their membership. Regarding these tensions, it does not seem to matter that they are different (which they are professionally), but it is mostly that their arrival changes the team.

Table 4.1. Interprofessional collaboration in a fluid team

	Membership change	**Membership difference**
Creating spaces		
Creating alternative communication lines	Inventing new positions & inviting temporary professionals	
Creating valued spaces	Inviting potentially valuable professionals	Inviting potentially valuable professionals
Bridging gaps		
Bridging knowledge gaps	Complementing each other's professional knowledge	Complementing each other's professional knowledge
Bridging communication gaps		Employing creative strategies to establish contact
Bridging partner matching gaps	Engaging with changing professionals per problem aspect	Contacting professionals in varying domains to find a match
Negotiating overlaps		
Negotiating responsibility overlaps	Identifying appropriate partners for negotiations	Negotiating professional roles and responsibilities
Negotiating safe work environments	Negotiating team membership	

4.3 Discussion and conclusion

Discussion

This research asks what interprofessional collaboration looks like in a fluid team context. This study finds that the taxonomy introduced by Schot and colleagues (2020) is functional for the analysis of interprofessional collaboration in fluid teams, but that there are distinct manifestations in fluid contexts. While team fluidity refers to the simultaneous presence of change and difference in team membership, we find that change is the primary driver for the specification of Schot and colleagues' (2020) taxonomy. This research makes a twofold contribution to the literature. First, by analyzing what team fluidity requires from professionals who engage in interprofessional collaboration (Schot et al., 2020; Wei et al., 2022). In doing so, we emphasize how challenges differ between fixed and fluid teams and how the teams' responses differ. We find that in fluid teams, there is a need to establish alternative communication lines that bridge internal and external interactions due to constantly changing membership and differences in membership. Professionals create valued spaces for collaboration, often based on fragile interpersonal connections. The reason being that professionals are unable to depend on established internal and external communication lines like in fixed teams (Nugus and Forero 2011, Gilardi, Guglielmetti et al. 2014). Furthermore, while fixed teams prioritize bridging perspectives, social differences, communication styles and task divisions (Falk, Hopwood et al. 2017, Schot, Tummers et al. 2020), fluid teams, however, encounter challenges in aligning communication lines, integrating diverse and changing work routines, and accommodating professionals from various professional domains who may not always match the typical profile or are unfamiliar to or intermittently part of the team. As a result, potentially relevant professionals may unknowingly be excluded from the team and professionals may need to invest additional effort in identifying and reaching out to appropriate professionals for the task. Moreover, fixed teams address potential conflicts and overlaps in roles and responsibilities that affect members' sense of belonging and trust (Mortensen and Haas 2018, Cristancho, Field et al. 2022). Fluid teams, however, also emphasize the importance of effective partner matching and ensuring safe work environment despite changing team compositions.

Our second contribution is the addition of empirical evidence from a frontline care context to research on team fluidity in management sciences (Kerrissey et al., 2020; Majchrzak et al., 2007; Valentine & Edmondson, 2015). Frontline care-settings are known for their direct engagement with clients, presenting distinctive challenges regarding team coordination, communication, and decision making that may diverge from those encountered in hospitals and disaster response teams. Additionally, frontline care often entails close collaboration between disciplines, including medical, social and mental healthcare professionals. Furthermore, frontline care demands prompt and adaptable responses to unforeseen situations. This means that in comparison to structured envi-

ronments such as hospitals, professionals may need to rely on improvisation and ad-hoc collaboration. The frontline care context of this study thus increases our theoretical understanding of the varied challenges and practices that are relevant when talking about team fluidity in teams across diverse professional contexts.

Limitations

The goal of this research was to describe what interprofessional collaboration in care looks like in a context of team fluidity. As such, the respondents were selected on theoretical grounds and the study's methodological approach allows for theoretical rather than empirical generalization (Feldman & Orlikowski, 2011). Further research should use other designs including larger study populations and various care systems to grasp possible differences between professional groups involved in care. Knowledge about professionals' health conceptions (Agresta, 2004; van Heteren et al., 2023), professional identities (Adams et al., 2006; Chreim et al., 2007; van Heteren et al., 2024) and professional-client interactions may help to understand possible differences and similarities in interprofessional collaboration between professionals. Moreover, in the decision to behave in a specific way in interprofessional collaboration in care, other factors may also play a role. Therefore, how interprofessional collaboration in a fluid team is linked to collaboration with the client environment should be further studied. Finally, future research should explore how clients experience interprofessional collaboration in fluid teams.

Conclusion

This study found that most interprofessional collaboration takes place informally through fragile interpersonal relationships in which membership change and difference create tensions. Even though professionals want to collaborate interprofessionally, this is difficult because membership in the team often changes and there are great differences between members.

The findings indicate that while some behaviors in fluid teams are similar to those observed in fixed teams, other behaviors are different because of different challenges. Different manifestations of interprofessional collaboration in fluid teams are particularly relevant given the prevalence of combined issues in today's context. This focus is especially pertinent because previous literature on interprofessional care (Schot, Tummers et al. 2020) has not consistently addressed team fluidity. In light of these combined issues, we recommend professionals to create awareness about the role of team fluidity in interprofessional collaboration. By doing so, future professionals in care and social welfare can be better prepared to navigate the challenges and capitalize on the opportunities presented by fluid team structures. In terms of training, future frontline professionals in care and social welfare should gain competencies such as quick adaptability to new communication styles and channels with diverse and changing team

members, as well as becoming empathetic and respectful listeners appreciating different perspectives and backgrounds, a fostering safe and inclusive team environment, and strong decision-making skills to navigate the complexities.