From territoriality to altruism in interprofessional collaboration and leadership

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Abstract
Interprofessional collaboration has become more and more necessary in health and social care, mainly because of the increasing specialization of services and the increasing professionalization of different occupational groups. Most interprofessional collaboration is at the same time also interorganizational and it is taking place within a complicated structure, where collaborative teamwork is combined with hierarchical co-ordination and control in a sort of matrix organization. Based on the literature on organization, leadership and collaboration, this paper discusses territorial behaviour among professional groups and agencies as a difficult barrier to interprofessional collaboration. In order to overcome that barrier, the concept of altruism is explored as an alternative to territoriality. Professional altruism as well as altruistic leadership is discussed as a condition and a possibility for interprofessional collaboration. The discussion is illustrated with empirical data from a case study of collaboration in vocational rehabilitation.

Keywords: Collaboration, co-ordination, territoriality, altruism, professional organization, leadership

Introduction
Collaboration between different professions has not only become more and more common but also more and more necessary in modern society, not least within the welfare system. This development is a result of the increasing specialization of welfare services and the increasing professionalization of occupational groups engaged in the provision of these services. This is particularly the case in health and social care (Meads & Ashcroft, 2005). The specialization and professionalization leads to a fragmentation of services provided for different patients and clients (Miller & Ahmad, 2000). Such fragmentation requires interprofessional collaboration, but in practice also interorganizational and sometimes even intersectoral collaboration (Axelsson & Bihari Axelsson, 2006).

There is growing research on interprofessional, interorganizational and intersectoral collaboration in health and social care. This research has, however, been focused mainly on different barriers to collaboration (e.g., Glendinning, 2003; Hall, 2005; Johnson et al., 2003). There are structural barriers in the form of existing legislation, organizational rules or regulations, and administrative boundaries that are difficult to cross. There are also barriers related to cultural differences between professions and organizations, for example specialized languages, attitudes and values that make communication and collaboration difficult. This orientation towards barriers and difficulties has led to a negative and rather
pessimistic view of interprofessional and other forms of collaboration. As Huxham and Vangen (2005, p. 80) have expressed it, “unless potential for real collaborative advantage is clear, it is generally best, if there is a choice, to avoid collaboration”.

A special barrier to collaboration is the existence of different forms of territorial behaviour. This is very common in most organizations, particularly among managers who regard their organizational units or areas of responsibility as territories that they have to defend. With such a view, interorganizational collaboration may be perceived as a threat to their territorial control. Thus, instead of collaborating, managers may be using all their energy and power to defend their territories (Bate, 2000). This behaviour is typical not only among managers, but also among professional groups. They are often defending their professional roles, competences and approaches against each other, which makes interprofessional collaboration very difficult (Abbott, 1988).

The aim of this paper is to discuss territorial behaviour among professionals and managers as a barrier to interprofessional collaboration. However, in order to avoid the pessimistic conclusions of the previous research, the concept of altruism will be explored as an alternative to territorialism and as a possibility for interprofessional collaboration and leadership. The paper is based on the literature on organization, leadership and collaboration, and on empirical data from a case study of interprofessional collaboration in vocational rehabilitation.

**Professional and organizational territories**

Territoriality is a concept that has been developed primarily in the field of zoology. A territory can be defined as a geographical area that is a more or less permanent habitat for an animal or a group of animals and actively defended against other animals (Kaufmann, 1983). This active defence of a territory is called territorial behaviour. Territoriality is a basic instinct not only among animals but also among human beings. As Lorenz (1966) has pointed out, human beings tend to defend their territories in the same way as animals, although the territories are often more abstract, such as organizations and areas of competence.

Professional territories are linked to different occupational groups and their fields of activity. In the sociological literature, a profession is usually defined as an occupation whose authority and status is based on a long education, usually academic, with a resulting licence to practice (Macdonald, 1995). Only those who have gone through this education and received their licence are regarded as qualified to practice such an occupation. Many professions have developed strict ethical rules and some professionals have also a legal responsibility for their work. The classic professions are physicians, lawyers and priests, but the increasing specialization in the modern society has led to a professionalization of more and more occupational groups, for example in health care (Freidson, 1986).

Professional groups were earlier regarded as pillars of society, motivated mainly by concerns for their patients or clients, but they are now seen rather as interest groups motivated by material rewards and privileges (Turner, 1991). One strategy for promoting their particular interests is to establish strong professional territories. According to Abbott (1988), all professions are striving for “jurisdiction” over their field of work. This means dominance over other professions within the same field and clear boundaries against those professions. If the boundaries are unclear or disputed, this may lead to struggles or conflicts between different professional groups. In the literature on professions, such conflicts are often described in terms such as “tribal wars” or “turf battles” (Bate, 2000).

Organizational territories are related to the strict division into units and levels that is characteristic of a bureaucratic organization structure (Morgan, 1997). In such a structure,
every organizational unit has a well-defined area of work and a manager with power and responsibilities that are regulated in a hierarchy of superior and subordinate levels. The task of the manager is to exercise power over subordinates in order to control their work, and to be responsible towards superiors for the performance of the unit. In addition, it is usually expected that the manager should be a strong advocate for the interests of the unit and to defend it like a territory (Mintzberg, 1973). An example is the budgetary process, where every manager is fighting for resources for his or her unit (Wildavsky, 1986). It is an important success criterion for a manager to increase the resources of the unit. This implies, at the same time, an enlargement of the organizational territory.

A professional bureaucracy is a special form of organization that includes both professional and administrative parts (Mintzberg, 1993). It is a big professional organization that, because of its size, requires extensive administration. Many welfare agencies are professional bureaucracies. Within the professional part of the organization are different professional territories and within the administrative part are different organizational territories. This may lead to territorial conflicts within both the professional and the administrative part of the organization. Moreover, there is a classic conflict between professionals and administrators that may further increase the level of conflict within this form of organization. This situation is very typical in human service organizations (Kouzes & Mico, 1979).

Collaboration and integration

There are many different and sometimes contradictory definitions of collaboration and similar concepts like co-ordination and co-operation. In fact, there seems to be a conceptual confusion within this area (Huxham, 1996). Many researchers are instead using the general concept of integration, which means simply to bring together different actors or activities (e.g., Kodner & Spreeuwenberg, 2002; Leutz, 1999). According to institutional economic theory, integration can be achieved either through a hierarchical organization or through the competition in a market (Williamson, 1975). In a hierarchy integration is achieved by the superior levels controlling the subordinate levels, while integration in a market is often described in almost religious terms as the result of "an invisible hand" (Chandler, 1977).

There is also a third way to achieve integration, namely through a network. This has been described mainly in the organizational literature (Thompson et al., 1991; Child & Faulkner, 1998). In a network, integration is achieved through voluntary collaboration between different actors. This can be regarded as horizontal integration in contrast to the vertical top-down integration that takes place in a hierarchical organization (Hvinden, 1994). By combining different degrees of vertical and horizontal integration, as shown in Figure 1, four main forms of integration can be derived (Axelsson & Bihari Axelsson, 2006).

![Figure 1. Different forms of integration.](image-url)
(1) A low degree of both vertical and horizontal integration means almost a lack of integration. This is the form of integration that exists in a market situation, where there is neither any hierarchical control nor any voluntary collaboration. Instead, the competition between different actors results in integration through contracting (Saltman, 1994).

(2) A high degree of vertical integration but a low degree of horizontal integration means that integration is achieved mainly through co-ordination. This is the form of integration that exists in a hierarchical organization. Decisions on integration are made on high levels in the hierarchical structure and implemented on lower levels, for example by bureaucratic mechanisms of supervision and control (Daft, 1995).

(3) A high degree of horizontal integration but a low degree of vertical integration means that integration is achieved mainly through collaboration. This is the form of integration that takes place in a network. The integration is based on a willingness to work together and it is implemented through intensive contacts and communications, for example in different teams or working groups (Alter & Hage, 1993; Ovretveit, 1993).

(4) A high degree of both vertical and horizontal integration means that integration is achieved through a combination of co-ordination and collaboration. This is a complicated form of integration, since voluntary collaboration may not be so easily combined with hierarchical co-ordination. This means a combination of two different organizational principles, which is called a matrix organization (Mintzberg, 1993).

All of these forms of integration may be effective ways of integrating welfare services, but some of them are more effective depending on the institutional context. Contracting requires, for example, a market for such services, while co-ordination requires a common hierarchy for all the actors involved. International comparisons have shown that the production of integrated services in health and social care takes place mostly through collaboration or co-operation between different welfare agencies (e.g., Leutz, 1999; Mitchell & Shortell, 2000; van Raak et al., 2003).

**Interprofessional teamwork**

Collaboration between welfare agencies is often organized in the form of multidisciplinary teams. Such a team can be defined as a small group of persons, usually from different professions, who are working together across formal organizational boundaries in order to provide services to a specific group of patients or clients (Ovretveit, 1993). There are many different types of multidisciplinary teams, for example temporary and more or less permanent teams. The members of the teams may be from many different agencies or professions, and some of them may be permanent members while others may be associated or more peripheral members (Schofield & Amodeo, 1999).

A multidisciplinary team can function as a more or less autonomous organizational unit, but the members of the team are usually not so independent from their respective agencies. They may be supervised by a team leader, who is elected by the members or appointed by the agencies involved (Cartwright, 2002). At the same time, however, they are also supervised by their managers in the different agencies. In addition, these managers often form a steering committee for co-ordination and control of the collaborative work. This means an organization with a combination of co-ordination and collaboration. The professionals are collaborating in multidisciplinary teams, but they are at the same time...
co-ordinated by a steering committee and by the managers of their different agencies. Figure 2 shows the basic principles of such a matrix organization.

Most interprofessional collaboration in health and social care seems to be taking place within such an organizational framework (Leathard, 2003; Mandell & Steelman, 2003). As mentioned before, this is a complicated form of integration, where horizontal collaboration in multidisciplinary teams is combined with vertical co-ordination by the agencies involved. This combination of vertical and horizontal integration may lead to conflicting demands and expectations, create double loyalties, and put the professionals as well as the managers in very difficult situations (Axelsson & Bihari Axelsson, 2006). In the organizational literature, matrix organizations are also regarded as one of the most difficult and conflict ridden structures (Mintzberg 1993).

**From territoriality to altruism**

It is easy to see that professional and organizational territoriality can be a serious barrier to interprofessional collaboration. At the same time, such collaboration may also be a serious threat to professional as well as organizational territories. In order to collaborate across professional boundaries, the professional groups must be able to see beyond their own interests and even be willing to give up parts of their territories if necessary. In the same way, the managers involved must be able to see beyond their own organizational units and be prepared to give up parts of their territories for the sake of interprofessional collaboration.

Such an ability to transcend and sacrifice particular interests for a common purpose is called altruism (Krebs & Miller, 1985). This is a philosophy that is quite the opposite of territoriality. Instead of defending a territory against others, altruism is based on a concern for others and for the society at large. It means, for example, that the provision of health and social services should be based mainly on the needs of the patients or clients. Moreover, in the provision of the services, the contributions of a particular profession or welfare agency should be seen in relation to the contributions of other professions or agencies involved. This means a more “holistic” approach to human needs and services (Higgins et al., 1994).

As described before, collaboration between professionals from different welfare agencies often takes place in multidisciplinary teams. Such collaboration may be difficult because of differences in professional languages, attitudes, values etc. A long process of development is therefore usually required for the professionals involved to learn about the different competencies in the team and to see the differences as an advantage rather than as a problem.
A great deal of professional maturity is also required to see the need for contributions from other professions in the provision of services. Both team leaders and managers of the collaborating agencies can play an important role in the development of such an altruistic attitude, for example by dealing with conflicts between professional groups and building trust between them (Axelsson & Bihari Axelsson, 2006). This development process can also be supported by different educational activities (Barr et al., 2005).

In the matrix organization described, there is collaboration not only in the multidisciplinary team but also in a steering committee of managers from the different agencies involved. The collaboration between the managers may be difficult because of differences in legislation, organizational rules and regulations, and administrative boundaries, including budgets. There may also be differences in organizational culture and in power and prestige between the agencies. In general, it is very difficult for managers to give in to other managers, since they may then be regarded as weak. The question is how the role of the managers can be changed in the direction of a more altruistic leadership (Kanungo & Medonca, 1996). A long process of development is probably required also in this case, where the managers have to learn to see their own agency in a larger perspective based on the needs of their clients or patients. This process may also imply a development from a traditional management of coordination and control to a more visionary leadership (Kotter, 1996).

There is of course also a relationship between professional altruism and altruistic leadership. As mentioned before, both team leaders and managers from the collaborating institutions can play an important role in the development of professional altruism. This presupposes, however, that they have an altruistic view of their work. Altruistic leaders can motivate their subordinates to transcend or give up parts of their professional territories for the sake of interprofessional collaboration. This is also called “transformational” leadership in contrast to “transactional” leadership, which is based mainly on territorial thinking (Bass, 1985; Bass & Steidlmeyer, 1999). In the same way, an altruistic view among the professionals can motivate the managers to transcend or give up parts of their organizational territories for the benefit of interorganizational collaboration.

Altruism in collaborative practice

During a ten year period between 1993 and 2003, there were a number of experiments in Sweden with collaboration between different welfare agencies in the field of vocational rehabilitation. The collaboration was mainly between the health services, the social services and the social insurance administration. This meant interprofessional as well as interorganizational collaboration. In addition, this collaboration included different levels of the Swedish welfare system, since local municipalities are responsible for the social services, while regional authorities are responsible for the health services and national authorities are responsible for the social insurance administration.

The most extensive experiment, which was called SocSam, included not only collaboration in vocational rehabilitation but also financial co-ordination between the different agencies in the form of a common budget for such rehabilitation. The national employment service was also involved in this experiment, but not on the same terms as the other institutions. The employment service participated in the vocational rehabilitation, but not in the financial co-ordination. The experiment took place in eight local communities in different parts of the country. It resulted in a new legislation making it possible for the different agencies in the rehabilitation field to form local associations for financial co-ordination.

During the period 2004–2008, the interprofessional collaboration within one of these local associations was studied through interviews with professionals and managers from the
different agencies involved. The interviews were semi-structured, focusing mainly on the processes and structures for collaboration and leadership. The interview data were processed in accordance with qualitative methodology (Taylor & Bogdan, 1998), which in this case means that the interviews were written out, interpreted and analysed with respect to their contents. The interview data were also combined with observations of meetings and rehabilitation activities, and studies of documents like minutes or notes from meetings, statistics, annual reports and evaluations (Hultberg et al., 2005).

This case study of collaboration in vocational rehabilitation will be reported in detail elsewhere, but for the purpose of this article some of the results can be summarized as an illustration of the development from territoriality to altruism in interprofessional collaboration and leadership. Before that, however, it is necessary to describe how the collaboration in this case is organized.

The organization of collaboration

The local association studied can be described as a matrix organization, or rather as several matrix organizations on different levels. The organization includes the local office of the employment service, the regional health authority, the municipal social service, and the local office of the social insurance administration. They are collaborating in projects directed towards different target groups in need of vocational rehabilitation, for example individuals with physical or mental disabilities, psychiatric problems, drug abuse etc. These projects are organized in the form of an association for financial co-ordination. The association has a budget to which all the agencies involved have contributed. It has also a manager, appointed by the institutions, and a small administration. There is a board consisting of the managing directors of the local employment service and the local social insurance administration, and politicians from the municipality and the regional authority. In addition, there is a working committee with managers from the different agencies, who are supposed to be supporting the manager of the association in management issues. Figure 3 shows the organizational structure of the association.

In the same way, every rehabilitation project can be regarded as a matrix organization of its own. The collaborative work is done mainly in multidisciplinary teams, supervised by team leaders appointed by the association, but the members of these teams are at the same
time also supervised by their managers in the different agencies. Many of these managers are also members of steering committees for the different rehabilitation projects. As a whole, this means a very complicated organization with a combination of horizontal and vertical integration on different levels. In such an organization, a high degree of both professional altruism and altruistic leadership is required.

Professional altruism

There are many different professions involved in the rehabilitation projects within the association studied, for example physicians, nurses, physiotherapists, psychologists, economists, lawyers and social workers. They have different educational backgrounds and practical experience, which means different views on vocational rehabilitation and different approaches to deal with the problems of rehabilitation. At the same time, they also represent different professional cultures and territories. According to the interviews, it has taken some time for the participants to realize the competences represented in the multidisciplinary teams and the use they can have of each other. In the beginning, there was mutual suspicion between the professional groups, which was based on a lack of knowledge of each other and also on prejudices resulting from territorial thinking.

Gradually, a lot of this suspicion has been replaced by positive experiences of being able to accomplish more together for the vocational rehabilitation of the patients or clients concerned. By meeting these patients or clients together, it has been possible to avoid them being sent around the different agencies in a vicious circle. It has also become clear to more and more professionals that they can supplement each other in different aspects of rehabilitation and also learn a lot from each other. A condition for such an altruistic attitude is, however, a high level of trust between the individuals involved. To build such a level of trust requires, in turn, a continual participation in the collaboration process. Unfortunately, in some of the rehabilitation projects, the participants have been replaced quite frequently, which means that the multidisciplinary teams have been in a constant process of trust building and not been able to take full advantage of the interprofessional collaboration.

Altruistic leadership

There are four different welfare agencies collaborating in the different rehabilitation projects, but this collaboration includes even more organizational territories in the form of different units within the collaborating institutions. The managers of the different units have been deliberately involved in the steering committees for the different projects or in the working committee of the association in order to reduce the risk for territorial behaviour. However, many of the managers interviewed have experienced wearing two different hats, both as manager for their organizational unit and as member of a steering committee for a collaborative project. Therefore, they have had loyalties both to their own agency and to the association for financial co-ordination, which has sometimes been a difficult balancing act.

The financial co-ordination with a common budget has reduced the risk for negative economic consequences, but, even so, some of the managers have felt that the collaboration has been at the expense of their own organizational units, at least in the short run. To avoid territorial conflicts, they have tried to see the role and tasks of the own agency in relation to the other agencies involved and particularly in relation to the patients and clients who are the targets of vocational rehabilitation. To take such a view has not always been easy, but it was pointed out in the interviews, as a basic condition for collaboration, that the managers are
able to see their own units in a larger as well as a more long-term perspective. According to the interviews, it has also been important for the managers to be willing to compromise and bend the rules if necessary for the collaboration. A problem in this connection is that collaboration may not be so good for their career. The managers are evaluated mainly for their contributions to the performance of their own agency, not for their capacity to collaborate with other agencies, even if it is good for the society at large.

**Concluding remarks**

Starting from a description of different forms of territorial behaviour between professionals and between organizations or their managers, this paper has discussed altruism as an alternative to territoriality and as a condition and a possibility for collaboration in the welfare system. This collaboration may be interprofessional, but it may at the same time also be interorganizational and sometimes even intersectoral. Such collaboration has become more and more necessary because of the increasing specialization of the welfare services and the increasing professionalization of the different occupational groups. It means a more holistic approach, which is required to meet the needs of the clients or patients.

Professional altruism may of course, like interprofessional collaboration, be regarded as a threat to the ongoing professionalization of many occupational groups, for example in health and social care. In the same way, altruistic leadership may also, like interorganizational collaboration, be regarded as a threat to established organizational territories. Moreover, an altruistic attitude may be regarded as unrealistic in a world that is based to large degree on professional and organizational boundaries, and on competition for resources between different professions and organizations. Altruism may also come into conflict with traditional criteria for evaluation of managers and professionals. It has been indicated that interprofessional collaboration is not always so good for their career.

It is difficult and it may take a long time to develop altruism in interprofessional collaboration and leadership, but it is a necessary development in order to reduce the ongoing fragmentation within the welfare system. A number of long-term development processes are required. First of all, a long experience is required to make the professionals involved open to the knowledge and competences of each other and learn to see the differences as an advantage for the collaboration. A trust building process is also required for the professionals to be able to take risks, to give up their routines, to resolve conflicts, and to create a common way of working and a culture that is based on the need for collaboration. In addition, an unconventional way to lead these processes is required, to support them so they really will be taking place, and to realize the importance of managing them with attention and understanding based on a holistic vision. This is the meaning of an altruistic leadership that may support the development of professional altruism for the benefit of the patients or clients in health and social care and other welfare services.

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