Title: International collaboration in health sciences research: manna, myth and model

Name: Zoe Jordan

School/Discipline: The Joanna Briggs Institute

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Abstract

"Individually, we are one drop. Together, we are an ocean."

-- Ryunosuke Satoro (2010)

Health care, health research and improved health outcomes is of international interest and efforts to achieve better health for the global community has been high on the agenda for some years. Calls to improve strategies for international linkages, particularly between developed and developing or low-income economies, are not new, but there is currently no model for how to effectively achieve this.

This thesis sought to identify public discourses around international collaboration in health research and to then conduct a discursive case analysis of an organisation that claimed to achieve international collaboration in health research. The analysis was informed by the work of Michel Foucault, whose notions of truth and power and the human experience were central to this thesis. This enabled an in-depth exploration of the utility of language in context but was also accompanied by more pragmatic investigative techniques that assisted with analysis of organisational specific aspects of the research.

Without a doubt, the results of this study demonstrate that international collaboration in health research was deemed a worthy and valuable cause that holds great potential to advance knowledge across borders and enhance the health of the global community. The resulting model for international collaboration aims to mobilise organisational discourse in such a way as to promote more comprehensive understandings and frameworks within
which collaborative processes can take place. By developing such a model it is hoped that the collective goal of improved health for all may not be such a distant possibility.
Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university of other tertiary institution to Zoe Jordan and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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Signed:

Date: 16th December 2010
Acknowledgements

“When you learn, teach. When you have, give.”

-- Maya Angelou (1991, p. 33)

To Professor Alan Pearson:
My sincere appreciation for teaching me that we all have the capacity to achieve if we have the will, to make a difference if we have the desire and to change the world if we have the courage.

To Dr Nathan Manning:
My sincere thanks for your continued encouragement, guidance and reassurance – even from afar.

To Amanda Fortanier:
My sincere gratitude for reminding me (constantly) to be brave and determined, even in the face of hardship and adversity.

To my family and friends:
Thank you for being there (you know who you are and what this means). You have taught and you have given and I am eternally grateful.
International collaboration in health research: manna or myth?

“Alone we can do so little; together we can do so much.”

-- Helen Keller (cited in Hermann 1999, p. 222)

SYNOPSIS

Health care research is a global necessity and international collaboration has been touted as an appropriate and effective strategy for achieving internationally relevant and meaningful results. The nature of international collaboration and associated benefits and burdens has been much debated. The relationship between international collaborative research efforts and local contexts as well as other operational and strategic issues are important considerations, and a model for successful and effective collaboration has to date proved elusive. For the most part, collaboration is an iterative, subjective and largely discursive process. It involves dynamic and inimitable contexts, groups and individuals who theoretically work to achieve common goals to mutual advantage. However, whether this myth is in fact a reality is yet to be determined.

INTRODUCTION

With the advent of faster international travel, more frequent, more advanced communications technology and opportunities for the generation and sharing of
knowledge, it is little wonder that those who work in the field of health research seek to collaborate both locally and with others around the world. International collaboration presents attractive and seductive opportunities for collegial interaction that have potential benefits for individuals and the broader community with regard to resolving global health issues.

Beyond the tangible benefits of knowledge sharing and capacity building are intangible issues surrounding opposing goals. Linguistically, and most commonly, collaboration is understood as being undertaken by two relatively equal partners who work together for mutual benefit. However, more often than not this is not the case.

Although there are no commonly accepted models for international collaboration, particularly within the field of health research, there are several principles that should be addressed. These include the meaning of the collaboration itself, the auspices under which collaboration is convened, the implications, complexity and discursive power constructs involved in the collaborative process, and the relationship between the organisations involved and their collective interests.

This study seeks to examine the establishment and consolidation of the discourses relating to international collaboration and demonstrate the way in which they function through the systematic production of knowledge and power in the specific field of health. It aims to offer an alternative perspective on, and approach to, the practice of international collaboration through various communicative strategies and functions. However, it is first necessary to establish the importance of international collaboration with specific reference to health research in order to be able to create a framework in which this might be successfully facilitated. In essence, it is believed that successful collaboration is largely achieved through effective communication strategy and, therefore, a significant proportion
of the study is both related to discourse and is conducted discursively. It seeks to understand how various groups interact on the global stage (with specific reference to health research) and to generate productive relationships with equal responsibility and benefit.

Beaver and Rosen (in Luukonen et al. 1992) noted collaborative linkages across national borders as early as the nineteenth century. These linkages increased toward the end of the century and international collaboration has grown in importance throughout the twentieth and twenty-first centuries. Luukonen and colleagues go on to assert that there are both internal and external factors relating to the scientific enterprise, and the ability and desire to collaborate internationally. Internal factors relate to authorship and field preferences while external factors relate to less expensive communication, government initiatives to increase international contacts and programs.

POSITIONING THE RESEARCH: A STORY OF SELF

Henry Miller (1957) once said that, “one’s destination is never a place, but a new way of looking at things” (p.25). I have always been fascinated by the notion of travel and of experiencing, appreciating and understanding other ways of living in and viewing the world. The curiosities of interpersonal communication and perception have always interested me, particularly across cultures, and travel has always provided opportunity to indulge my inquisitive nature on this topic. Travel can provide adventure and exciting new encounters but equally it can be uncomfortable and uneasy. For the most part I have found that people across the world are surprisingly similar but they are also different and travel, as Mark Jenkins (2003) once observed, can provide an opportunity to bear witness to the incredible kindness and bottomless cruelty of humankind.
Having completed my undergraduate degree, a Bachelor of Arts majoring in literature, and having spent the obligatory year travelling extensively in Europe, I started working for the Joanna Briggs Institute in 2000. This followed on from a brief contract as a research assistant for a University Nursing Department, where my interest in health research began.

In 2003 I continued to follow my interest in communications completing a Master of Arts (Communication Studies) in which I undertook a discourse analysis of media representations of terrorism, titled ‘Political Discourse in Mass Media Coverage of Acts of Terrorism: A Comparative Study of Coverage of the Twin Towers and The Bali Bombing’. The thesis, which examined coverage of both events in the United States and Australia, demonstrated the striking similarity of coverage between these two Western countries and the discursive patterns utilised to communicate and manipulate messages sent to the general public. Dominant Western ideologies became the central mechanism and subsidiary discourses affected the way in which those ideologies worked. The coverage of events shaped the discourses, which in turn shaped public response and ‘legitimised’ the actions of governments. Rather than being a chronicled distillation of objective reality, the discourses represented in the media were very much a product of human decisions and emotion and a strategic device used to shape and influence the public.

Now, as an Associate Director within the Joanna Briggs Institute, responsible for Communications and Collaboration, I felt that a study of international collaboration as part of a Doctor of Philosophy program provided a perfect opportunity to combine my interests in international relations, communications and health. It is important to declare that I have an intimate knowledge of the Institute, and its internal and external publications and communication strategy, and have been closely involved in their development over the course of the last ten years. I also know many of the individuals involved and have
knowledge of conversations and discussions that were not necessarily formally recorded. However, I believe this experience has placed me in a unique position to be able to analyse the discourses of the Institute and to make an assessment of their strategic utility over the course of the Institute’s evolution.

**GLOBALITY, COLLABORATION AND HEALTH**

For thousands of years, cultural and economic exchanges between different societies – brought by traders, explorers, conquerors or settlers – have played a role in repeatedly spreading and altering the epidemiology of diseases. Social and economic policy, although designed to reduce global health inequalities, have contributed to shaping worldwide changes in diseases.

The development of global initiatives and programs, such as the World Health Organization and the United Nations Millennium Declaration, aimed at improving health outcomes across the world, is indicative of the increasing international focus on world health. Some view this global approach to the improvement of health outcomes as inevitable, while others believe the reality is quite contrary to the intent of the endeavour. At the Millennium Summit in 2002 Theo-Ben Gurirab (in Crossette, 2000), the foreign minister of Namibia and the General Assembly president for the preceding year said that:
“Globalization is seen by some as a force for social change, that it will help to close the gap between the rich and the poor, the industrialized north and the developing south, but it also is being seen as a destructive force because it is being driven by the very people, the colonial powers, who launched a global campaign of imperial control of peoples and resources in what we call now the third world. Can we trust them?”

More recently, during his welcome address at the World Health Summit in Germany (2010), Kofi Annan, former Secretary General of the United Nations, spoke of global health issues as being everyone’s problem, regardless of geography. He stated:

“We now live in a world where the outbreak of disease in a distant region is of direct and immediate relevance to our own wellbeing; where progress in less developed countries and regions is to everyone’s economic benefit; and where ensuring that everyone gains from globalization and the many remarkable advances of medicine is of crucial importance to global long-term security. Our responses to health challenges are thus best coordinated at the global level …”

Similarly, Dr Julian Frenk (2010), Mexico’s former health minister, called for a renewed commitment to global collaboration on health in order to “meet the challenges and reap the benefits of an increasingly interdependent world”. He went on to add, “As we enter a new era of global health, knowledge will continue to be the key asset to sharpen our understanding of problems and to create novel solutions. In our turbulent world, still scarred all too often by intolerance and exclusion, science remains as the most powerful force for enlightened social transformation.”
In their book, *Real collaboration: what it takes for global health to succeed*, Rosenberg, Hayes, McIntyre and Neill (2010) tackle the question of how global partnerships can perform better and call on global leaders to come together to agree on the most critical health priorities and how to address them. They also call for strategies to make funding agencies and bodies such as the United Nations accountable for their stated missions.

Calls such as these only amplify the need for the responsibility of collaboration to become inherent in attempts to resolve global health issues and for clear principles and strategies for collaborative action to be identified and implemented into the collective thinking around this central challenge.

**KNOWLEDGE: THE TECHNOLOGISATION OF DISCOURSE**

Language has become an important aspect of social processes. Fairclough (in Wetherell, Taylor and Yates 2001) discusses the emergence of a ‘knowledge-based’ economy and thus an economy that is also ‘discourse-based’ in the sense that new knowledges are produced, circulated and applied in production as new discourses. Quoting Lyotard (1986-7), Fairclough writes, “we can say that knowledge and, hence, language and other forms of semiosis become commodities (Fairclough in Wetherell, Taylor and Yates 2001 p. 231)”. Fairclough (in Wetherell, Yates and Taylor 2001) also speaks to the “technologization of discourse” as a conscious attempt to shape and control language to meet organisational objectives. Within the context of this study the manipulation of discourse to achieve particular organisational goals is clearly demonstrated. Specific research knowledge and broader organisational knowledge is produced, distributed, acquired, manipulated, used and re-used to serve specific political and/or organisational agendas and needs.
Discourse is utilised to design, structure and restructure processes to initiate and manage international collaboration.

In particular, internal and external communication strategies played an important discursive role in the case analysis phase of this study. They engineered the subject positions of those involved until external perceptions reflected internal perceptions of the vision, mission and relationships between various parties who sought to collaborate.

**SEEKING A TRUTH**

Foucault seeks to contextualise notions of truth and knowledge, rather than provide absolutisms regarding activity and meaning. Similarly, this study sought to examine the discourses surrounding international collaboration in context and to provide some insight into how and why groups seek to collaborate across international borders. Thus, the premise of this research was a desire to establish whether true international collaboration in the field of health research does in fact exist, if so to what extent and how successfully? Or is it simply a myth that has been discursively created in order to satisfy the desire to be seen as 'doing good'.

The approach to exposing these discursive strategies is to work from a set of basic research questions concerning the underlying nature of international collaboration in this field and to develop an integrative model of collaboration. The specific questions addressed in regard to international collaboration in this research were:

- How is international collaboration defined in the discourse and what are its discursive characteristics?

- How is discourse utilised to facilitate international collaboration?
A health related international research collaborative provides the context for this study. In this sense it seeks to offer a perspective on international collaboration that is particular to the social, ideological and cultural context of health, and more specifically health research as the organisational field. The premise of this research therefore, was to establish whether successful international collaboration in health research is in fact a gift from heaven or an absolute myth; a true and real reflection of a desire to work across nations, or a fairytale complete with heroes and villains.

**MAKING A DIFFERENCE AND REMAINING DIFFERENT**

The challenge, and often the tragedy, of international collaborations in health research is that groups are expected to become homogenous entities that think, behave and conduct their business (i.e. the business of research) in the same way. What is desirable is an approach that allows for difference as much as similarity. While a collective consciousness and identity is required in order for collaborations to successfully move in the same direction, it is important that there is a certain degree of autonomy and an ability to recognise and value difference within that model.

**CONCLUSION**

A study of this nature is timely. With the steady increase of international connectedness via travel, commerce, communication, politics and, of course, research, it is important to establish ways of knowing each other, communicating effectively and collaborating to meet mutual goals and imperatives. A model for international collaboration that provides clear
strategies and direction to those who seek to participate in global health research and to build productive international relations is essential.
Globalisation and collaboration: a conflict of visions

“The year 1500 marks an important turning point in world history ... The European discoveries made the oceans of the earth into highways for their commerce ... ”


SYNOPSIS

It is important to understand the principles of international collaboration in health and the influence of globalisation as a phenomenon. The history of globalisation is sketchy at best and a clear definition of the term is much debated and often problematic. However, the benefits and burdens on the delivery of health services around the world are unquestionable. I do not set out here to make a case for globalisation one way or another, but simply to outline the arguments both for and against, to examine the potential impact of the phenomenon on the health agenda and to serve as a prelude to the analysis of discourses surrounding the need for and approaches to international collaboration in the health sector, with a particular focus on health research.

INTRODUCTION

Since December 1999 in Seattle every meeting of the leaders of the World Trade Organisation, the World Bank, the International Monetary Fund and the world's richest
Background

nations (the G8) has been met by increasingly large and often violent demonstrations (Feachem 2001). Globalisation is frequently said to be an inevitable component of progress in travel, information technology and communications. However, others (like the demonstrators at the G8) see increasing global economic and social integration as a conspiracy by the rich and powerful to exploit the poor and underprivileged (Feachem 2001).

That said, international collaboration is increasingly encouraged, particularly in the area of health research. International collaboration in health care and health care research is thought to expand the pool of talent available for tackling research problems, facilitate the exploration of shared features in different systems and strengthen the research capacity of less developed countries.

The case for international collaboration has been particularly strong in dealing with the health problems that affect poor populations in developing countries. However, research in this area is still relatively neglected. According to a 1999 report by the Global Forum for Health Research, only 10% of the $50-60 billion that is spent every year for health research is used for research on the health problems of 90% of the world’s people (the so-called 10/90 disequilibrium) (Global Forum for Health Research 2000). The advent of multinational organizations and international collaboration has many benefits and challenges related to leadership, knowledge sharing and management, motivation, engagement and integration of diverse cultures. However, there is a dissociation between the distribution of diseases and conditions that occur largely in developing countries and the scientific expertise that is required to tackle them – capacity that is largely in developed countries.
Global threats to health evolve over time as a result of planned and unplanned human activities or changing environments that bring humans in contact with organisms that are capable of causing diseases. While the evolution of some of these health issues may be positive, as in the case of the discovery of antibiotics that enabled humans to survive bacterial infections, others could develop into major public health threats. For instance, two decades ago no-one could have foreseen the devastation that HIV, a previously unknown virus, would cause worldwide. The increase of such threats will see an increase in the necessity for successful international collaboration, particularly with disparities between communities in our global society.

It has been suggested that the expansion of international collaboration in health research should be an important element of future strategies, coupled with mechanisms for strengthening the research capacity of developing countries. Research shows that international collaboration is increasing. A number of studies have examined communication strategy relating to geographically dispersed teams. Despite this body of evidence and the growing literature that international collaboration in health research is a good thing, little is known of the success of such collaborations and there are calls emphasising the need for evidence of its effectiveness (Ansari, Phillips & Hammick 2001). We have an incomplete understanding of the dynamics of collaboration at the global level and how it differs from nationally or institutionally based research or localised collaboration.

International collaboration with regard to research, clinical standard setting, disease management, health promotion and education will become increasingly important in the next decade. It is important that we have a comprehensive understanding of effective techniques and strategies for international collaboration and communication within the health care arena.
EMERGENCE

A brief history

Intense international contracts are not new. From time immemorial the forces of trade, migration, war and conquest have bound together people from different places. The Greek philosopher Diogenes coined the expression 'citizen of the world' in the fourth century BC (Frenk & Gomez-Dantes 2002). What is new is the pace, range and depth of integration. This integration is increasingly referred to as being a result of globalisation, but from where did the term originate and how do we define it?

It is interesting that the ways in which major events are constructed and deconstructed through public discourse continues to be a topic of interest across disciplines. Particularly, according to Fiss and Hirsch (2005), with regard to large-scale transformations such as globalisation. These transformations are marked by discursive struggles over their impact and the outcomes of these struggles may facilitate or impede their acceptance. The discourse on ‘globalisation’ is not shaped uniformly; it consists of different threads regarding different aspects and notions (Backhaus 2003). There is no consensus about the ‘beginning’ of globalisation, although it has been suggested that globalisation has existed since as early as the fourteenth Century. What is clear is that globalisation must be understood within a historical context over centuries, with contemporary forms of globalisation distinguished by the intensity of cross-border (and in some cases transborder) activities taking place and the geographic extent of their reach (Lee & Yach 2006 in Merson, Black & Mills 2006).

Many academics and historians treat globalisation as a recent phenomenon, however others believe it has existed for much longer. O'Rourke and Williamson (2002) identify
several perspectives on the history of the globalisation phenomenon. They identify several authors who place the start of globalisation very early in the course of history (associating globalisation with a single world economy with a worldwide division of labour or with ‘big bang’ significance to events such as Christopher Columbus’ discovery of the Americas). Others contend that globalisation in fact began much later. The focus of their work accounts for only one dimension of globalisation, that of international commodity trade, and thus in their estimation globalisation did not begin 5000 or even 500 years ago but in the early nineteenth century thus making it a very modern phenomenon.

However, there are others who would argue that globalisation has simply occurred in various stages or phases (although even this is contested in the literature in terms of the number of phases, when they occurred and what they involved).

In their demonstration of framing and sense making of an emerging concept Fiss and Hirsch (2005) conclude that the discourse around globalisation emerged in response to greater United States involvement with the international economy. They argue that there have been three periods in the discursive development of globalisation, noting its emergence as occurring between 1984-7, a period of setback and consolidation between 1988-94 and its further spread and contestation between 1995-98. Similarly, Woodward et al. (2001) places the start of globalisation firmly within the economic sector, stating, “Economic globalisation has been the fundamental driving force behind the overall process of globalisation over the last two decades” (p.876).

Twining (2006) would argue that globalisation remains a figment of our collective imaginations, stating that “to think of humankind as a community in any strong sense is at best an optimistic aspiration that we are a long way from achieving” (p. 509). He goes on
to add that to talk of “global law, global governance, or global ideology as if these concepts have any precise meaning is simplistic and potentially threatening” (p. 509).

While there is no consensus over the historical identity of the phenomenon it has never the less become a catchcry in our collective vocabulary. Thus, in order to determine potential strategies for how we function and collaborate in the global community, it is essential to seek some clarity around the concept of globalisation and how it is defined.

**Globalisation defined**

The term globalisation is a highly contested one that is defined in a wide range of ways. Globalisation became current in the West in the domains of economics, politics, sociology and the mass media during the 1990s. However it has been around for significantly longer with some arguing that it was well underway by the time of the Industrial Revolution in the eighteenth and nineteenth centuries (Zolo 2007).

There are numerous and widely differing definitions of ‘globalisation’ as the complex processes of integration (both global and regional) currently underway in the world (Zolo 2007). It has been variously viewed as the expansion of modernity; as being in constant tension with the parallel phenomenon of ‘fragmentation’ (or localisation), and as being associated with universalisation, thus, some clarification is required.

Globalisation refers to increasing connectivity, integration and interdependence in economic, social, technological, cultural, political and ecological spheres. It can be defined as a set of processes leading to the creation of a world as a single entity, relatively undivided by national borders or other types of boundaries (Bettcher & Lee 2002).

Herdman (2004) refers to globalisation as world systems being distinct from national ones and internationalisation as the relationships between countries where the nation-state
remains important. It is broadly understood as articulating how the contemporary world is becoming more interdependent, with events in one part of the world having an impact elsewhere. However, if we are to understand the implications of globalisation on health care and research, a more precise understanding of what it means is required (Lee & Yach cited in Merson, Black and Mills 2006). Lee and Yach go on to suggest that a strict definition of globalisation focuses on the transcendence of geography, whereas looser definitions often use the term to describe related phenomena such as liberalisation, Westernisation and universalisation.

Since the appearance of the term in the early 70s, the scholarly and popular discourse of globalisation has grown steadily in both amount and complexity (Fiss & Hirsch 2005). Numerous terms are used indiscriminately throughout the literature when attempting to define globalisation and its impact: internationalisation, localisation, Americanisation, fragmentation, homogenisation, universalisation, nationalisation, regionalisation and the list goes on. Does it shrink distance or increase it? Does it increase cultural heterogeneity around the world or decrease it?

Many will argue the negative impact of globalisation citing destructive effects on democratic processes, workers rights, the earth’s natural resources and the authority of the nation state. Others suggest a positive impact with growth in international trade leading to widely shared benefits. Some will challenge its existence altogether while others will conceive it is simply a matter of degree (Fiss & Hirsch 2005). Globalisation has been characterised both as a condition of modernity and as ushering in a new and distinctively different 'global age' (Fiss & Hirsch 2005).

Its root term, ‘global’, refers to ‘the whole world’ and the World Health Organization describes globalisation as the “increased interconnectedness and interdependence of
peoples and countries” (WHO website 2008). The essence of globalisation has been described by Lee et al. (2002) as a range of processes that are changing the boundaries that separate human societies from each other, “in some cases resulting in greater interconnectedness, but in others new divisions”, that can be “spatial, temporal or cognitive” (p. 16). Thus, if we are to define globalisation in this broad way we can begin to explore how it is influencing health, health care delivery and health related research.

Benefits and burdens

As if its history and definition weren't contentious enough there is also significant debate around whether globalisation is having a positive or negative impact on the ‘global community’ and once again the camps are firmly divided. On the one hand globalisation is seen to increase opportunities and capacity for development; on the other it is argued that globalisation is more likely to increase the burden on some countries while increasing the prosperity of others. Lane (2006) states that:

“Globalisation is a contested set of phenomena because the countries participating in the process benefit differently. When groups believe that they stand more to gain than lose, then they endorse globalisation. However, when they fear the consequences of globalisation, then they oppose it”. (p. 4)

Negative perspectives on globalisation highlight potential destructive effects relating to democratic process, workers’ rights, the earth’s natural resources and the authority of the nation-state, while others propose that growth in international trade leads to widely shared benefits and a general civilising effect (Fiss & Hirsch 2005).
The potential impact of globalisation spans economic, environmental, political, cultural and technological spheres and both positive and negative perspectives exist for each. The economic impact of globalisation seems as obvious a place to begin as any. Whether it is foreign investment and trade, foreign aid, or its potential to increase or decrease economic divides, globalisation is a force to be reckoned with. Kahler (2004) states that globalisation has “produced a redefinition of economic security in light of the risks posed by cross-border networks of non-state actors and by the economic volatility of the new global environment” (p. 485).

Economic globalisation is tightly linked with global governance issues and how to manage the increasingly integrated economic marketplace. As many opponents as supporters have met the establishment of groups such as the World Trade Organization, the International Monetary Fund or the World Bank. Some critics “wish to extend the benefits of economic globalisation and to create institutions of global governance which are far more democratic than the existing collection of international agencies” (Griffin 2003, p. 790).

Similarly, the globalisation debate is strong with regard to its impact on the environment, global resources and responsibilities. While some argue there is great potential for the global community to rectify environmental damage through collaboration, others claim that the theory does not reflect the reality. Mander (2001) argues, “the idea of globalisation as some kind of environmental strategy is ridiculous”, believing that the ideologies and structures that drive globalisation are intrinsically opposed to the survival of nature (p. 33). Some would argue, however, that “greater movement of goods, services, people and ideas can lead to economic prosperity, improved environmental protection, and a host of other social benefits” (Kwong 2005, p. 28).
Social and cultural homogenisation is also frequently addressed in current debates about the impact of globalisation and is often associated with ‘Americanisation’. Many fear that globalisation is imposing cultural uniformity, integration or Westernisation, resulting in a loss of any sense of individual cultural identity or exclusivity. The commodification of culture and its perceived global spread is pitted against the existence of quite individual value systems that suggest we are a long way from cultural assimilation.

Legrain (2003) suggests that globalisation has the ability to “free people from the tyranny of geography” (p. B7), presenting opportunities to choose an individual cultural experience that enriches lives. Lieber and Weisburg (2002) state:

“Culture takes on this pivotal position not only because of its intrinsic significance, but precisely because it has become so bound up with the most fundamental questions of human identity in its many dimensions: personal, ethnic, religious, social and national. As a result, controversies about culture often have less to do with surface level phenomena: McDonalds, American tastes in music, language, art and lifestyle, than with deeper forms of alienation that owe more to the changes and disruptions brought by modernization and globalization.” (p. 275)

In addition to this, the advent of new technologies such as the internet, mobile phones, personal computers and telephone mainlines has seen enormous impacts on the diffusion of innovation and information, but to what extent? Many have claimed that the result of such technological revolution has been the ‘death of distance’, but for whom is this a reality? It has certainly been widely acknowledged that the impact of this revolution has not occurred across the board internationally.
Such polarised perspectives regarding the potential impact of globalisation do not stand-alone. They are equally reflected in the literature concerning the potential impact of globalisation in health care, including the development and dissemination of knowledge and information. The other important issue to factor in is that all of the above elements, all of which are influenced by globalisation, have an impact on global population health status, health systems and health care delivery.

**International aid versus international collaboration**

In September 2000, 189 member states of the United Nations committed to achieving eight goals when they signed the Millennium Declaration. These goals (the Millennium Development Goals), for which targets have been set for 2015, relate to the eradication of extreme poverty, achieving universal primary education, promoting gender equality and the empowerment of women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental stability and developing a global partnership for development.

The achievement of these goals will rely heavily on the participation of international organisations and the development of international partnerships. Three of the eight goals are related specifically to overcoming health related issues predominantly in developing countries. However, it is important to emphasise at this point that the current research project did not seek to examine international partnerships or collaboration to assist in the provision of aid, but sought to establish principles of international collaboration in the conduct of health related research.
Notions of power and influence in global relations and collaboration

It could be argued that globalisation, colonialism and imperialism are all demonstrations of the exertion of power and influence of Western, ‘developed’ countries over low-income economies in order to reorder values and behaviours to ‘conform’ with the interests of (supposedly) ‘superior’ classes. They are all systems of political and social control that seek to change other cultures and practices under the guise of ‘education’ and ‘development’. These attempts at change do nothing but further Western agendas, ideologies, aspirations and interests.

Banerjee and Linstead (2001) differentiate forces of globalisation and colonialism with a discussion of the tension between local knowledge and global communications of knowledge. They state that “globalisation transforms the power knowledge nexus in relation to ‘other’ knowledges: while colonialism generally served to undervalue or invalidate other knowledges” (p. 691). However, they go on to conclude that while we may live in an information age we do not necessarily live in a knowledge age and that all the remarkable advances in communications technology have not ensured we have anything better to communicate (Banerjee & Linstead 2001).

Colonial perspectives would suggest that Third World communities continue to be marginalised and that they are inflicted upon rather than integrated. Brown and Bell (2008) however, believe that the global diffusion of public health knowledge and practice is not a one-way flow. They argue that within public health discourses there are sources of knowledge and practice that “provide a counter to dominant western-based conceptualisations” (Brown & Bell 2008, p. 1572). However, they also go on to examine the World Health Organization global strategy and recognise that when subjected to a more subtle reading it might be thought of in post colonial terms, stating that the strategy is
“driven by a desire to integrate developing nations into a common narrative regarding the current and future condition of global health” (Brown & Bell 2008, p. 1577).

Dirlick (2002) believes that globalisation returns the world to a condition of colonialism, stating “the urge to integrate the world into a system through colonization has given way to managing a world where those who are unable to integrate or seem superfluous are simply marginalized, and colonial management is replaced by the management of chaos” (p. 440). Can we read globalisation as really just more of the same? Is globalisation simply the exertion of power of North over South; the penetration of multinational corporations and debt dependency? Is it just another ‘turn of the screw’?

Munck and O’Hearn (1999) suggest that the challenge is to construct a discourse of social change, but without transcending the realities of the everyday lives and struggles of individual contexts. However, the ‘end of diversity’ is not nigh. Attempts at international collaboration have fallen flat and a new model is required. One that consciously accounts for difference and takes into consideration the unique and inimitable needs of those inhabitants of the ‘global’ community in their own distinctive context.

**INFLUENCE**

Whether globalisation has a positive or negative impact on an individual, or indeed a population, largely depends on where they are in the world. The information and communications revolution are often quipped as being at the heart of economic and social globalisation. It is claimed that such technological change has and will continue to transform the way people live (Cairncross 1999). However, while globalisation has been
said to shrink distance it does not make it irrelevant as many communities remain only
tenuously connected with others.

Although globalisation, as a term, is as ubiquitous as it is contested, there is none the less
clear evidence that the market in health care is becoming steadily more international – that
national borders in this sphere are gradually becoming more porous (English et al. 2002).
Much has been written in policy circles about globalisation, and much scholarly work has
been done and continues to be done on its health consequences (Navarro 1999).

Globalisation is affecting a broad range of social spheres and is affecting individuals and
population groups in different ways. Contemporary forms of globalisation appear to be
widening inequalities in health for certain individuals and population groups. The capacity
to address inequalities requires that we understand globalisation in relation to the broad
determinants of health (Lee & Yach in Merson, Black & Mills, 2006).

Within the health sector globalisation is impacting in a variety of ways. Health
professionals are increasingly mobile (impacting on recruitment and retention issues),
health consumers are also travelling more (impacting not only on service provision but also
the transfer of communicable diseases). New technologies and the provision of health
services and information across international borders have meant significant changes to
the way in which health services are provided.

**Mobile communities and the globalisation of disease**

The impact of globalisation and the consequences of living in a global community cannot
be underestimated. An increasingly mobile global community and the phenomenon of the
global burden of disease is a clear reminder of how globalisation affects daily practice and
the need for health professionals to be cognisant of the dynamics and implications for living in a global community.

International travel, tourism and migration have impacted on the transmission of infectious diseases such as HIV/AIDS or SARS. In the last two decades new diseases like these and re-emerging diseases such as tuberculosis and malaria have impacted the “poor and disadvantaged sectors to a much greater extent than they have affected the more privileged sectors of the population, in both the richer and poorer countries of the world” (Harris & Seid 2004, p. 13). They add:

“The global impact of high-speed forms of transportation and the increasing movement of people around the world have made it possible for the microbes that accompany them to move faster around the world. This acceleration in the movement of people has had far reaching health effects. It has given rise to new patterns in the spread of infectious diseases, and facilitated the rapid transmission of these diseases.” (Harris & Seid 2004, p. 13)

A new phenomenon labelled ‘medical tourism’ has also evolved, whereby patients travel abroad to receive health care (particularly elective procedures) at a cheaper rate (Murphy 2008). Equally, the mobilisation of populations has affected the recruitment and retention of health professionals internationally. International agencies are actively discouraged from engaging in recruitment in areas such as South Africa in order to preserve national expertise and prevent the ‘brain drain’ caused through migration (Seloilwe 2005). This international mobility has also seen major outflows of doctors from India, South Africa and Cuba and of nurses from the Phillipines and Jamaica (Drager et al. 2001).
New technology and information provision

One of the most widely recognised benefits of globalisation is improved access to information and resources. Technological advancements, particularly in relation to communications (television, telephone and computer), have been claimed to revolutionise the way we live and the way we think (Cairncross 1999). However, in a call to demystify globalisation it was stated “there is nothing intrinsically good or bad in the flow of capital, labour and knowledge around the world; its goodness or badness depends on who governs the flow, which determines who benefits from it” (Navarro 1999, p 220).

The benefits of access to information and resources that can be attributed to globalisation have not been equally distributed. Global and local disparities exist in the distribution of the burden of disease and the allocation of resources (Hilfinger Messias 2001, p. 10). It is therefore necessary to forge collaborative partnerships and build bridges across disparate worlds in order to link global values with local actions.

Seloilwe (2005) states, “Microchip, internet, fax, cellular phones, electronic banking and e-learning are recent technologies, but they have transformed the world, creating today’s ‘knowledge economy’. Knowledge is no longer the preserve of particular areas or people; it is for everyone, just a click away. Modern technology and globalisation have profoundly affected economic, political and social activity in every part of the world” (p. 571).

Research and innovation

In spite of increases in international activity, nursing theory, research, education and practice often do not reflect a global orientation and as a consequence are not always globally relevant (Davidson, Meleis, Daly & Douglas 2003). In a recent report the World Health Organization called for global collaboration to meet threats to global health security.
It stated, “A more secure world that is ready and prepared to respond collectively in the face of threats to global health security requires global partnerships that bring together all countries and stakeholders in all relevant sectors” (WHO Report 2007, p. xxi). It also recognised that while many of these partnerships are already in place, there are serious gaps that weaken the consistency of global health collaboration.

Hubbard and Love (2004) call for a new trade framework for global health care research and development. Their primary concern is with the marketing monopolies that surround the research, development and manufacturing of new drugs in the global community. They propose a model of funding that would encourage access to medicine for all, thus diminishing the pressure of pharmaceutical companies to set high prices and exclude those who cannot afford to pay (Hubbard & Love 2004).

Not only has globalisation affected the conduct of primary research, drug related research and development, but also secondary research in the form of evidence synthesis and its transfer into clinical settings. While advances in communication and information technology have made developments in this area a semi-global enterprise, access to the results of this work remain limited and their application localised. Limited resources, a knowledge chasm, the need for a systems approach and poor accessibility have all been listed as factors that contribute to deviations from an evidence-based approach to care (Clancy & Cronin 2005). However, it has been suggested that to succeed in globalising the evidence, “policy makers must realise that opportunities to do so will be tempered by three competing values: choice, efficiency and equity” and that finding a balance between “globalising the evidence and localising the decisions will improve delivery of health care world wide” (Eisenberg 2002, p. 167).
Health service delivery

It is clear that while globalisation has brought with it several challenges to health service delivery so too has it created opportunities. The advent of globalisation has seen an increase in researchers sharing knowledge and resources in order to improve global health outcomes. This acceleration of access to information and expertise is increasingly important, but its effectiveness is uncertain.

Muir Gray (2001) highlights that, despite the differences in the ways in which health services around the world are funded and organised, many of the major problems in the delivery of health care are similar and include increased costs, lack of capacity, variation in rates of delivery and delayed implementation of research into practice.

The changes arising from globalisation extend to the field of health in three main ways:

- Processes of global change are shaping the broad determinants of health (employment, housing, education, water, sanitation, agriculture etc).

- There is growing evidence that health status and outcomes are being influenced by globalisation, with different impacts on specific individuals and populations (new patterns of health and disease linked to global restructuring of human societies).

- As a consequence societies must adapt their collective responses to changing health determinants and outcomes (Lee & Yach cited in Merson, Black & Mills, 2006 p. 687).

There is significant literature around the impact of globalisation on the health of the poor and those in low-income and developing countries. Although the issues that accompany ill health (such as increased poverty through loss of earnings) occur across the board, they
are most acute in low-income and developing economies, which has contributed to the “skewing of benefits of globalisation away from them” (Drager et al. 2001, p. 75).

Whether these changes to health and health care delivery are perceived as positive or negative, they clearly exist. The challenge is to determine the direction we pursue from this point in time with regard to how researchers can collaborate to establish solutions are broadly relevant and applicable and can potentially result in better health outcomes in the global community.

DIRECTION

For health professionals in particular, the World Wide Web, fast international travel, increasing international knowledge exchange and the unrelenting focus on efficiency, efficacy and effectiveness all conspire to demand much greater collaboration (Pearson 2007). However, it has been argued that many nations and cultures are more alike than they are different and that in a time when most countries find it difficult to meet the increasing demands for health care, the need for international collaboration has never been greater (Pearson 2007).

In our turbulent world, health remains one of the few truly universal aspirations (Frenk & Gomez-Dantes 2002). It has been argued that international collaboration, therefore, offers a concrete opportunity to reconcile national self-interest with international mutual interest. Increasing communication, in the face of the growing complexity of health systems, has made international comparisons more valuable than ever – countries can benefit from a process of shared learning (Frenk & Gomez-Dantes 2002).
Often the conventional basis for collaboration is a perception of similar need and/or convergent initiatives. As useful as such collaboration may be, building a partnership on common needs but divergent initiatives may be more useful. It could build on the complementarity of experience and expertise, as well as the commonalties. Divergent legacies and orientations may point to the richest areas for learning through cross-fertilisation to facilitate transfer of insights and expertise (Leatherman, Donaldson & Eisenberg 2000).

International collaborations with an emphasis on mentorship and partnership are likely to contribute solidarity in striving for global health from a sound scientific basis (Davidson, Meleis, Daly & Douglas 2003). It has been argued that a culture of partnership and collaboration will create a body of knowledge that, despite having a global perspective, will be locally and culturally appropriate. Thus an international collective approach is required to respond to the impact of globalisation on health and health care.

Cooperation in health occurs in three areas: consensus building and advocacy, cross-learning and transfer of knowledge (exchange of experience and transfer of knowledge), and production and sharing of international public good (Walt & Buse cited in Merson, Black & Mills 2006).

One of the great strengths of international organisations is that they can ignore political, geographical, or cultural barriers and draw on ‘epistemic communities’, networks of professionals with recognised expertise and competence in a particular domain and an authoritative claim on policy-relevant knowledge within that domain or issue area. From such cooperation and sharing emerges consensus statements, guidelines and manuals, and various measures of best practice (Walt & Buse cited in Merson, Black & Mills 2006).
The expanding knowledge base is what made the twentieth century health revolution possible. Knowledge improves health through two mechanisms. The more obvious is the invention of specific technologies, such as the production and administration of drugs and vaccines, but knowledge is also the basis for health promoting behaviours (Brundtland 2001). It has been argued that scientific knowledge is relevant to all people and that our challenge is to spread that knowledge and make it more integral to the way people lead their lives (Brundtland 2001).

In the future, better means of communication among health services researchers worldwide should lessen the informational and methodological gap between developed and developing countries. And through this process, we will, ideally, come to visualise the generic concerns of our field as those associated with the assurance of minimum basic health care of all (DeFriese 2001).

Advancing the cause of health in the new global community will require a new commitment to cooperation among the private, governmental and non-profit sectors. If it can be argued that the twentieth century has been a world of competition and conflict, surely there is opportunity for the world of the twenty-first century to be a world of cooperation and collaboration. Central to this new view of the world will be global partnerships (Richardson & Allengrante 2001).

If we want to shape the global health agenda of tomorrow, we need to work today to transcend the narrow agendas of individual sectors and regions and create the kinds of partnerships that will strengthen civil society throughout the world. We need multilateral partnerships that bridge nations and peoples (Richardson & Allengrante, 2001).
CONCLUSION

It is important to establish a context within which the principles of international collaboration in health can be discussed. While for some, globalisation has meant enormous growth in wealth and income, for others the process has meant an enormous deterioration in their standard of living, health and wellbeing. Understanding the evolution and impact of globalisation on the delivery of health services is essential if we are to establish a direction for the future. It is vital that the health research community establishes strategies and principles for the creation of meaningful, influential international partnerships to improve global health outcomes.
Truth, power, discourse and Foucault

“The work of an intellectual is not to mould the political will of others; it is, through the analyses that he (sic) does in his own field, to re-examine evidence and assumptions, to shake up habitual ways of working and thinking, to dissipate conventional familiarities, to re-evaluate rules and institutions and to participate in the formation of a political will (where he (sic) has his role as citizen to play).”

-- Michel Foucault (1984)

SYNOPSIS

Foucault’s approach to discursive analysis, the human experience and notions of truth and power are central to the methodologies utilised to inform this piece of research. Discursive inquiry involves an exploration of language and description of culture, which differs from other more traditional methods of investigation. Thus, it is important to provide a description of the comprehensive framework for analysis utilised to examine discursive statements, their construction and discontinuities in relation to international collaboration in the global community.
INTRODUCTION

Discourse analysis is not a coherent paradigm of well-defined procedures, but a proliferated theoretical approach, which covers a broad range of methodological devices. Discourse analysis represents both a methodology and a method that embodies a strong social constructivist view of the social world (Phillips & Hardy 2002). It shares the concerns of other qualitative approaches with the meaningfulness of social life, however it attempts to provide a more profound interrogation of the precarious status of meaning (Phillips & Hardy 2002).

Traditional approaches to qualitative research assume a social world and then seek to understand it, however discourse analysis attempts to explore how the socially produced ideas and objects that populate the world were created in the first place and how they are maintained and held in place over time (Phillips & Hardy 2002). While other qualitative approaches work to understand or interpret social reality as it exists, discourse analysis endeavours to uncover the way in which it is produced. It examines how language constructs phenomena not how it reflects and reveals it (Phillips & Hardy 2002).

This study utilised a three dimensional framework for studying discourse (informed by the work of Michel Foucault). This approach, utilized within the context of a global community, facilitates an in depth examination of inter and intra organisational power relations and communication and their impact on international collaboration.

**Discourse, international collaboration and organisational analysis**

Mainstream organisational theory is generally oriented to the design and operation of successful and economically run organisations and utilises scientific methodologies in order to control and regulate future events by their causes. However, it has been argued
that such mainstream theories are unable to adequately address other aspects of organisational existence and that this failure follows from its insufficient notion of power (Abel 2005).

Fairclough (2005) argues that studies of organisations need to include analysis of discourse. Organisational discourse research is both conceptually and methodologically diverse (Jian, Schmisseur & Fairhurst 2008). Ascribing to Derrida’s dictum that we are written as we write, a discursive analysis of organisational communication in relation to international collaboration is not only appropriate, but also essential. While Derrida was more concerned with the micro-logic of writing and the socio-technical division of labour in organisations, Foucault’s analysis of writing and the development of knowledge and power in institutions are complimentary to the aims of this study.

There are significant opportunities for the application of methods of discourse analysis for the purpose of unveiling discursive constructions within organisations, both at a local and international level. New organisational forms (such as widespread acceptance of information technology, globalisation of business, trade and culture, as well as resistance to it and increasing importance of knowledge) have seen an increase in the use of discourse analysis in organisational and management theory (Phillips & Hardy 2002).

By conceptualising international collaboration as a discursive construction, it is possible to explore the implications for organisations seeking to participate in this type of activity. Utilising such an approach further enables the exploration of various knowledge and power relationships between organisations and countries who attempt to collaborate to undertake health related research projects.
THEORETICAL FRAMEWORK

Michel Foucault (1926-1984) has been described as one of the most influential philosophers of this century. Foucault’s work is frequently referred to in a broad range of disciplines. He combined philosophical topics with historical investigation. Rejecting the tag postmodern or structuralist, it can be said that Foucault’s contribution to the history of ideas involves a rethinking of three central concepts: discourse, power and knowledge. He refused to be identified with any specific or universally applicable method, rather calling for his works to be utilised as a toolkit from which others could take and use various elements to suit their own individual needs.

Discursive analysis, history and the human experience

A diagnosis of the present is the way in which Foucault utilised the examination of history. According to this approach, history is a way of seeing that the present is just as strange as the past and things and events may or may not be connected (Kendall & Wickham 1999).

Foucault rejects the idea of the self-governing subject, pointing out that what comes between ourselves and our experience is the grounds upon which we can act, speak and make sense of things. For Foucault, one of the most significant forces shaping our experiences is language. We use language to explain our ideas and feelings to others but also to ourselves (Danaher, Schirato & Webb 2000).

Archaeology, genealogy and discourse are the tools Foucault uses to give some order to history, at the same time as giving history the ‘power-knowledge twist’ that makes the Foucaultian approach so distinctive (Kendall & Wickham 1999). One requires a field of knowledge (archaeology), a narrative collection of rules (genealogy) and a mode of relation to one self (ethics) in order to critically analyse the human experience (Hoy 1986).
Discourse, as the means through which a field ‘speaks’ of itself to itself, plays a major role in the operations of the field. So in mapping out a discursive field, Foucault wants to trace where particular instances of discourse have occurred, to make connections between these instances and to bring them together to identify a particular discursive formation.

Archaeology

When taking a Foucauldian approach to discourse analysis, the statement, as it occurs in the archive, is the main concern. Archaeology helps us to explore the networks of what is said and what can be seen in a set of social arrangements: in the conduct of an archaeology, one finds out something about the visible in ‘opening up’ statements and something about the statement in ‘opening up’ visibilities (statements and visibilities mutually condition each other) (Kendall & Wickham 1999).

Kendall and Wickham (1999) go on to add that archaeology requires an investigation of the relationship between words and things; a focus on how a system of statements works; an attempt to formulate rules for the replicability of statements, ways of being and acting (i.e. the way statements produce subject positions); describe surfaces of emergence, attempts to describe institutions and describe forms of specification (how phenomena are made accessible to us).

Discursive practices, according to Foucault, are like events that occur at a particular time and create effects within a discursive field. Thus, they should be examined historically in order to understand and explain how particular world-views come into being: the continuities and discontinuities that contribute to how people make sense of the world and how this evolves. Knowledge and truth are not ahistorical in this sense, but are produced by epistemes and are caught up in struggles of power. Foucault (1972) states:
“… history proper was concerned to define relations … between facts or dated events: the series being known, it was simply a question of defining the position of each element in relation to the other elements in the series. The problem now is to constitute series: to define the elements proper to each series, to fix its boundaries, to reveal its own specific type of relations, to formulate its laws, and, beyond this, to describe the relations between different series, thus constituting series of series, or tables …” (p. 8)

Mills (1997) states that Foucault’s archaeological analysis of discourse is important because he is not simply analysing the discourses which are circulating in our society at present; what he wants us to see is the arbitrariness of this range of discourses, the strangeness of those discourses, in spite of their familiarity. He also wants to chart the development of certain discursive practices, so that we can see that, rather than being permanent, as their familiarity would suggest, discourses are constantly changing and their origins can be traced to certain key shifts in history (Mills 1997).

Genealogy

Foucault distinguishes between archaeology and genealogy when he says:

“If we were to characterise it in two terms, then ‘archaeology’ would be the appropriate methodology of this analysis of local discursivities and genealogy would be the tactics whereby, on the basis of these local discursivities, the subjected knowledges which were thus released would be brought in to play.”

(Foucault 1980, p. 85)
According to Kendall and Wickham (1999), archaeology is Foucault’s method and genealogy is not so much a method as a way of putting archaeology to work, a way of linking it to our present concerns.

Carabine (cited in Wetherell, Taylor & Yates 2001) offers this explanation: “Foucault's genealogy offers us a lens through which to undertake discourse analysis and with which we can read discourses” (p. 268). Carabine goes on to add that this lens means we can read discourses as, on the one hand, being infused with power/knowledge and, on the other, as playing a role in producing power/knowledge networks. In other words, if Foucault's archaeological analysis relates to discourse in historical context, then his genealogical analysis seeks to explain how these discourses were produced and changed over time. It reconceptualises discursive events in terms of truth and power in the construction and deconstruction.

**Discursive regularities, statement and archive**

For Foucault, a discourse is not a set of utterances, which is stable over time; he tries to work against notions of progress and development, which dominate liberal ways of thinking. Instead of viewing history as a simple progression towards greater civilisation or equality, Foucault argues that history is discontinuous; there is not a seamless narrative. He is therefore concerned with charting moments of discontinuity when discursive structures undergo radical change (Mills 1997).

Foucault seeks a level of analysis, which takes account of concepts, their continuities, their interconnectivities, small shifts and radical re-ordering. He argues that the rules for the formation of concepts operate within the discourse rather than being external to it.
(Foucault 1972). It is these regularities or irregularities that form the conditions of existence for any discursive formation.

Statements, according to Foucault, are not structures, but a function of existence that properly belongs to signs on the basis of which one may then decide, through analysis or intuition, whether or not they make sense. To understand the variety of styles of statements, Foucault found that it was necessary to take into account other systematically changing discursive practices, such as who has the right to make statements, from what site statements emanate and what position the subject of discourse occupies (Dreyfus & Rabinow 1982).

For Foucault, a discourse is not only a group of statements for which conditions of existence are definable, but also a historical event or an archive of historical statements. Archaeology constitutes a way of conducting historical analysis of discourse. To be more precise archaeology seeks to describe the *archive*, the term employed by Foucault to refer to "the general system of the formation and transformation of statements" existent at a given period within a particular society (Foucault 1972, p. 146). The archive determines both the system of enunciability of a statement-event and its system of functioning.

According to Carabine (cited in Wetherell, Taylor & Yates 2001) a discursive strategy refers to the ways that a discourse is deployed. It is the means by which a discourse is given meaning and force, and through which its object is defined. It is a device through which knowledge about the object is developed and the subject constituted. So, within this study, it is a device through which perspectives on and strategies for international collaboration are put into discourse.
Deconstructing ‘truth’ and power relations

For Foucault, discourse is more than just spoken word; it is the mechanism through which power operates. Foucault’s conceptualisation of power and the relationship between power and knowledge are important to the examination of organisational existence and functioning.

Early conceptions of power were characterised as conditioned upon a conflicting relationship among self-determining agents who consciously advanced their individually defined interests against the understood interests of equally self-determining others (Abel 2005). In contrast to this view, Foucault expands the dimensions of a definition of power and suggests that power is not something that is “acquired, seized or shared, something one holds on to or allows to slip away” (Foucault 1990, p. 94).

Power, for Foucault, is not just the ruthless domination of the weaker by the stronger and is not, in fact, something that is owned at all. Rather, Foucault believed power to be everywhere; not because it embraces everything but because it comes from everywhere (McHoul & Grace 1993). By conceptualising power as not necessarily a dominant influence distorting both discourse and practice but as potentially enlightening and legitimate, it provides a means of going on discursively and rationally toward a positive future in a consensual society (Abel 2005).

Foucaultian power has been described as something not held, but practiced. It is not imposed from above, but is a series of relations within a system or society; there is no ‘outside’ to power, no place untouched by it; in the end, power produces desires, formations, objects of knowledge and discourses, rather than primarily repressing, controlling, or providing an outlet for powers already held by pre-existing subjects, knowledges or formations (Nealon 2008).
Foucault also recognizes truth as a form of power and uses the term ‘games of truth’ to emphasise that, while public institutions authorise their activities by claiming to be speaking the ‘truth’, these truth claims are dependent on institutional and discursive practices. He defines a game of truth as a set of rules by which truth is produced. Foucault’s thesis on power highlighted the essential link between power relations and their capacity to produce the truths we live by. He argued that “we are subjected to the production of truth through power and we cannot exercise power except through the production of truth” (McHoul & Grace 1993, p. 59).

In his studies of governmentality, Foucault defines power as ‘actions on others’ actions’ and views it in society as not a fixed or closed regimen, but an endless and open strategic game (Burchell, Gordon & Miller 1991).

Organisational discourse can be clearly linked with power constructs. Power, in such circumstances, is not an attribute or possession of any individual, but rather a characteristic of human interaction. Power arises between individuals in their relationships through discursive practice, or conversation. Conversations are more than simply the spoken word; they are a mechanism through which power operates. Foucault’s conceptualisation of power and the relationship between power and knowledge are important to the examination of organisational existence and functioning.

Shaw (2002) argues that professional discourses allow us to argue both retrospectively and prospectively about our work practices. She states “… they legitimise the kind of causality we will use to articulate the nature of our human agency, the kind of difference we can make, the scope and limitation of our power to influence the evolution of events” (p. 96).
When Foucault analysed discourse he was not examining the system of its language or its rules of construction (as he was not concerned with knowing what makes it legitimate or makes it intelligible, or allows it to serve in communication). Foucault was more concerned with how statements come in to being, the conditions that enable their emergence and how they are related to previous statements or events (Burchell, Gordon & Miller 1991).

A modernisation or postcolonial theoretical lens

Williams (2003) suggests that analysis of international collaboration must be informed by more than one theoretical perspective in order to capture its complexity. It is further suggested that the theoretical perspectives of modernisation and post colonialism “contribute different viewpoints to the investigation of international research because they lead to different conclusions about international relations and knowledge building” (Williams 2003, p.504).

Within the context of an investigation into international collaboration, modernisation theory focuses on the contributions of industrialisation, science, technology, and cross national contact to positive international allegiances (Williams 2003) and persists because it appears to promise and deliver productivity, and through that productivity, improved quality of life (Rabinow cited in Williams 2003). According to Guillen (cited in Williams 2003) these hopes are echoed in the current enthusiasm surrounding globalisation.

Postcolonial theories are the foundation of an alternative reading of international relations and research. As the name implies, postcolonial analysis has its roots in criticism of the colonisation that formed the Third World. Analysis is particularly concerned with the cultural forms that are associated with relations of domination and subordination within and between nations, races and cultures (Mishra & Hodge cited in Williams 2003).
Postcolonial theorists contend that the development of international networks continues the exploitation of the periphery for cheap labour and resources, with impoverished Third World nations obliged to participate to survive (Beckman cited in Williams 2003; Smith cited in Williams 2003).

It is the substance of these theories that Williams (2003) suggests provides a lens through which to analyse international collaborations and its potential to benefit or exploit those who participate. It was hoped that by applying these theoretical lenses to the current research it would be possible to ascertain how various discourses were developed and how they were enacted for specific audiences.

CONCLUSION

A discursive approach to the analysis of international collaboration and organisational communication strategy provides a unique opportunity to gain insight and understanding of the motivations, driving forces and strategies that are utilised, and potentially, manipulated to achieve individual and groups objectives.
Selections from the ‘toolbox’

"I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area ... I would like the little volume that I want to write on disciplinary systems to be useful to an educator, a warden, a magistrate, a conscientious objector. I don't write for an audience, I write for users, not readers."

-- Michel Foucault (1974, p. 523-524)

SYNOPSIS

Discourse analysis was utilised in this study to investigate processes of social construction relating to principles of international collaboration in the global community. As such, a variety of sources of discourse were examined, informed predominantly by the work of Michel Foucault, to seek out new understandings of power relations and other factors influencing collaboration and communication in this context. This chapter provides a description of the methods utilised for searching, data collection, and data analysis in order to identify the discourses and their modes of construction. What has emerged is not a 'blueprint' of how to conduct discourse analysis as there is not a set method. However, it attempts to provide an overview of the assumptions and general considerations of the researcher, and a description of the practical steps taken to undertake this piece of research.
INTRODUCTION

Discourse analysis approaches, at least as employed in organisation theory, sociology and literary studies, are not methods in the positivist sense of precisely defined sequential steps in search of universally applicable laws, but rather approaches emphasising hermeneutic, iterative journeys of discovery by (re)reading individual texts in the context of the whole and their social context and then (re)considering the whole as manifested in individual texts (Heracleous 2006).

“There is no method to discourse analysis in the way we traditionally think of an experimental method or content analysis method. What we have is a broad theoretical framework concerning the nature of discourse and its role in social life, along with suggestions about how discourse can best be studied.” (Potter & Wetherell 1987, p. 175)

Cheek (2004) suggests that discourse analytic approaches are not necessarily aiming to seek closure in terms of producing the only possible reading, and that to seek to do so may, in fact, be in conflict with the tenets of the approach employed.

Although the philosophy underpinning discourse analysis differentiates it from other forms of analysis, when it comes to actual studies, the boundaries between discourse analysis and other qualitative methods are sometimes blurred. Researchers have consequently employed a range of interpretive techniques (Phillips & Hardy 2002).

Phillips and Hardy go on to state that what makes a research technique discursive is not the method itself, but the use of that method to carry out an interpretive analysis of some form of text with a view to providing an understanding of discourse and its role in constituting social reality. To the extent that they are used within a discourse analytic
ontology and epistemology, many qualitative techniques can become methods (Phillips & Hardy 2002).

METHODS

Discourse analysis is broad and complex, and there is no singular or established ‘gold standard’ approach to undertaking research of this nature. The practical elements of undertaking this type of research are often not clearly described and are highly variable. Discourse analysis, like other qualitative analytical approaches, is not a unified, unitary approach (Cheek 2004). Much has been published about Foucault’s seeming reluctance to clearly delineate a research method, particularly with regard to genealogy (Graham 2005) and Potter and Wetherell (1987) note that it is “a field in which it is perfectly possible to have two books on discourse analysis with no overlap in content at all” (p. 6).

Thus, as a strict Foucauldian approach is challenging, many researchers adopt approaches that are Foucauldian informed but follow the more specific guidance of other authors. This research utilises techniques formulated by the likes of Potter and Wetherell (1987), Wetherell, Taylor and Yates (2001) and Hardy, Palmer and Phillips (2000), while attempting to maintain a Foucauldian perspective on the identification and analysis of discourse and discursive practices.

In addition to this, for communications researchers, discourse analysis is the close study of “talk (or text) in context”, a method that, according to Tracey (cited in Schiffrin, Tannen & Hamilton 2001, p.734), is to be distinguished from other forms of discourse analysis. It provides communications researchers with a compelling way to study a variety of human interactions, including the ways in which organisations are created and made sense of.
While none of the intellectual commitments of communications scholars are necessarily unique to the discipline, it is important to position this research within this field.

DATA COLLECTION

Within this framework there were three discrete phases – a discursive analysis of public discourses, a discursive case analysis and an integrative analysis. The collection and management of data is particularly problematic for discourse analysts. Discourses are not shaped uniformly, and consist of different threads of information that are invariably constructed, deconstructed and sometimes reconstructed by an assortment of individuals and groups with differing motivations and knowledge. It is thus important to be clear about the discourse that is sought, and how it is to be identified and collected for analysis.

DEFINING THE DISCOURSE

Assumptions and definitions

If the primary objective of this study is to establish effective strategies for international collaboration and communication through an analysis of discourse it is important to define each of these terms.

Discourse and communication

Within the context of this study it is particularly important to distinguish between two terms, that of ‘discourse’ and ‘communication’, which are here treated as two distinctive but inextricably linked variables for analysis.
There has been considerable debate around distinguishing between the terms ‘discourse’ and ‘communication’ in the organisational communication and discourse literature. Notions surrounding how each of the terms should be defined are often blurred and contentious with much overlap, particularly around the attribution of meaning and construction of social circumstances. As this study is concerned with examining organisational ‘discourse’ in order to develop a clearer model for international communication and collaboration, it is vital that the meaning of these two terms within this context are defined at the outset.

Alvesson and Karreman (2000) conceptualise two types of discourse, namely ‘little d’ and ‘big D’ discourse. ‘Little d’ discourse refers to talk and text in local social interaction and ‘big D’ discourse (or Discourse) refers to culturally “standardized ways of referring to/constituting a certain type of phenomenon” (p. 1134). Foucauldian discourse then seems to align most closely with ‘big D’ Discourse in the sense that its examination accounts for discourse in a broader way in terms of its impact on the development and representation of social realities.

Foucault (1972) postulates discourse in the following way:

“Instead of gradually reducing the rather fluctuating meaning of the word ‘discourse’, I believe I have in fact added to its meanings: treating it sometimes as the general domain of all statements, sometimes as an individualisable group of statements, and sometimes as a regulated practice that accounts for a number of statements.” (p. 80)

Communication recognises the relationship between conversation and text, which explains the way organisations emerge in communication (Taylor & Van Every cited in Jian, Schmisseur & Fairhurst 2008). However, others object to the use of the term
communication, dismissing it as ‘transmissional’ and ‘individualistic’ and not a form of social action in the same way as discourse is (Edwards cited in Jian, Schmisseur & Fairhurst 2008).

For the purpose of this study, communication is considered to be the means by which information or messages are imparted, transmitted or conveyed, whereas discourse focuses on what is, or has been, said and how such statements have come into being. Thus, discourse is viewed as operating or taking effect through communicative functions – communication activities or tactics are the symbolic interactions through which discourses are revealed.

Organisational discourse

There are many definitions for what might constitute organisational ‘discourse’ and its role in organisations. Broad interpretations of discourse see it as more than simply a linguistic device or semiotic mechanism. Rather, it is viewed as being central to the social construction of reality. Grant et al. (2001) argue that “our everyday attitudes and behaviour, along with our perceptions of what we take to be reality, are shaped by the discursive practices and interactions that we are involved in and exposed to” (p. 7). Further to this, Mumby and Clair (1997) state that:

“In this sense, when we speak of organisational discourse, we do not simply mean discourse that occurs in organisations. Rather, we suggest that organisations exist only in so far as their members create them through discourse. This is not to claim that organisations are nothing but discourse, but rather that discourse is the principal means by which organisation members create a coherent social reality that frames their sense of who they are.” (p. 181)
Grant and Hardy (cited in Fairclough 2005) state that the term ‘discourse’ has been defined as sets of statements that “bring social objects into being” (p. 919). They refer to the term organisational discourse as the “structured collections of texts embodied in the practices of talking and writing that bring organisationally related subjects into being as those subjects are produced, disseminated and consumed” (p. 919).

For the purposes of this study, organisational discourse is defined as sets of texts that bring an object into being. Thus discursive analysis requires an examination of language, the production of texts and processes of communication, and the interactions between actors in organisational and institutional settings (Grant et al. cited in Hardy et al. 2000). Studying discourse is therefore a powerful way to explore processes of organisational life and how such processes might influence and/or facilitate communication strategy and capacity for collaboration, international or otherwise. It can be used to examine how organisations attempt to enact strategic intentions regarding collaboration, with a particular focus on power relationships.

**International collaboration**

The other concept that may require some clarification is the term international collaboration. Collaboration can take many forms, particularly within the health research arena. It can occur locally, nationally or internationally; between individuals or groups of various sizes and orientations; it can be unidisciplinary, interdisciplinary, multidisciplinary, transdisciplinary (or pandisciplinary); and can involve any combination of clinical and education settings. This study was specifically interested in research and innovation in
health on the global stage, however this concept required some clarification prior to starting the search phase of the study.

Katz and Martin (1997) distinguish between inter and intra forms of collaboration, be it at an individual, group, department, Institution, sector or national level. They argue that the difficulty in defining the term lies in part with the notion that research ‘collaboration’ is largely a matter of social convention among scientists.

Lundin, Frinking and Wagner (2004) describe “global techno-scientific collaborations” as collaboration between partners from different countries for the development of “know-how and innovation”. Each partner retaining its institutional identity and maintaining distinct ownership structures marks these collaborations.

According to Walker, Craig and Stohl (cited in Walker 2003b), collaboration involves “two or more autonomous stakeholders joining their resources, knowledge, and expertise for a limited amount of time to achieve a mutually, and generally innovative, end” (p. 1).

The term is taken here to mean an ongoing working relationship of geographically dispersed groups with a common goal (i.e. collaboration in the field of ‘knowledge generation’ that produces culturally meaningful and appropriate results rather than ‘knowledge transfer’ or merely the communication of findings).

For the purpose of this study international collaboration takes an inclusive approach (i.e. not just Western collaboration, but also involving developing countries) and relates to the development of partnerships (as in the Lundin, Frinking and Wagner definition) with the express purpose of strengthening capacity to generate and share knowledge across international borders.
SEARCHING

Within this study there were two sets of data, described as ‘corpora’. A ‘corpus’ is a collection of linguistic data, which is seen to be representative of a certain type of text, interaction or discourse (Yates cited in Wetherell, Taylor & Yates 2001). The first corpus related to public discourses and the second to organisation specific discourse, each of which explored the features of language around different aspects of international collaboration.

Corpus one – the extant literature

References to the concepts of globalisation and internationalisation in health in the public domain were identified through a structured search of international media databases and the ‘grey’ literature. An initial search of broad literature and internet search engines identified primary search terms: ‘international’, ‘global’ and ‘worldwide’ and ‘collaboration’. These were piloted and it was soon recognised that a comprehensive list of variations on the term ‘collaboration’ would be required. Thus, collaboration was utilised along with terms like: ‘cooperation’, ‘partnership’, ‘alliances’, ‘association’, ‘networks’, ‘relations’, ‘communication’, ‘strategy’, and ‘coalition’.

Additionally, the search was further narrowed to include terms such as: ‘health’, ‘health care’, ‘health research’, ‘research’ and ‘development’.

These terms were then searched in Medline, CINAHL, Academic Search Premier, Academic OneFile, PubMed (biomedical sciences), ScienceDirect, Scopus, Google, Google Scholar, Factiva (newspapers), eLibrary (newspapers).

Initial searches proved to be less fruitful than anticipated. The literature retrieved during this early phase seemed a limited body of work relating only to positive aspects of
international collaboration. Lengthy discussions with supervisors and consultation with other experts resulted in an extended search of grey literature utilising terms such as: ‘Western imperialism’, ‘colonialism’, ‘post colonialism’, ‘neo-colonialism’ and ‘collaborative research’, ‘politics’ and ‘research’. It was hoped that these search terms would result in a more comprehensive or broad literature that would account for different perspectives on international collaboration.

**Search limits**

Papers were selected that broadly addressed the purpose and process of international collaboration specifically with regard to the conduct of research in health and health care. As such, papers were excluded that reported on specific projects that were conducted internationally as little information was provided regarding the discourse around why the collaboration was necessary and how it was undertaken, other than to report that it happened. Papers were also excluded if they addressed collaboration regarding education or specific disease related research projects.

Papers were limited to English only due to time and financial constraints. The fact that this excludes a range of international perspectives and discourses needs to be acknowledged and accepted as a limitation of the present study. That said Fairclough (cited in Wetherell, Taylor & Yates, 2001) speaks of the emergence of a global language and a global order of discourse that are obviously connected. He states, “English is both the vehicle and source of much of the globalisation of the order of discourse” (p. 231). However, while many would argue that English has become the common scientific language others, such as Kikuchi (2007), would argue that while some countries have been modernised they have not necessarily been completely Westernised, making communication challenging. Thus, it is fair to say that a certain proportion of literature is likely to have been missed in this
analysis. Certainly the searches conducted reflected a number of articles published in languages other than English that may have been relevant to the current study, and could have provided further insight into the discourses of non-English speaking countries in relation to strategies and perspectives on international collaboration.

**Corpus Two – Discursive case analysis**

The Joanna Briggs Institute, with its twenty-plus international Collaborating Centres, were studied as a case-example of contemporary attempts to pursue a global approach to research, innovation and knowledge sharing between diverse nations and cultures. The discourse for this phase will comprise the international dialogue embodied in the interactions of that group, namely through printed publications such as the annual report and minutes of the committee of directors meetings over the course of fourteen years.

Phillips and Hardy (2002) suggest that naturally occurring text are a better source of data for discourse analysis because they are actual examples of language in use. Therefore, in order to ascertain discursive constructions of international collaboration in an international organisation, naturally occurring texts would include different kinds of archival data stored by the organisation such as annual reports, minutes of international meetings and texts that accumulate outside of the organisation such as media articles and other reports. Defining ‘text’ even more broadly the use of logos and other promotional ‘artefacts’ were examined. It was anticipated that the combination of these discursive cues and how they are produced, disseminated and consumed would provide insight into how the organisation worked to collaborate internationally.

In order to ensure a manageable corpus of texts to assist in exploring the construction of approaches to international collaboration, organisational discourse data was limited to
samples of formal text, rather than informal text and did not include interview data, although this was an earlier conception in the research process.

The corpus, therefore, was indicative of texts associated predominantly with decision-making, policy and practice, or those produced in response to particular events or discussions (i.e. use of the company logo, annual reports over time). The natural limits placed over this data were related to the lifespan of the organisation (i.e. fourteen years).

**Saturation**

The notion of saturation in discourse analysis is different to other forms of qualitative analysis. According to Phillips and Hardy (2002) the endpoint comes “not because the researcher stops finding anything new, but because the researcher judges that the data are sufficient to make and justify an interesting argument” (p. 74).

**ANALYSIS**

A discursive approach to analysis informed by Foucault was utilised. As such it sought to identify objects of discourse as they manifest themselves within each phase of the study in order to gain an in depth understanding of the impact of globalisation on international collaboration in health care. While discourse analysis has similarities with other forms of qualitative analysis, as mentioned earlier, the principal difference between discourse analysis and other data analysis is not the initial process of analysis but the analytic concepts involved. Wetherell, Taylor and Yates (2001) state that these differences derive from how the research is located theoretically. They state:
“Analytic concepts are given by the theoretical tradition, the research questions, and so on. The discourse analyst searches for patterns of language in use, building on and referring back to the assumptions she or he is making about the nature of language, interaction and society and the interrelationships between them. It is this theoretical underpinning rather than any sorting process which distinguishes discourse analysis”. (p. 39)

Organisational discourse as a strategic resource

Hardy et al. (2000) developed a model of discourse as a strategic resource comprising three circuits (activity, performativity and connectivity). The first circuit comprises discursive activities on the part of the individuals who are attempting to use discourse strategically. The circuit of performativity occurs when the discursive concepts evoked in discursive statements are embedded in the larger discursive context. Finally, if the circuit of activity and performativity intersect they create a circuit of connectivity. Hardy et al. (2000, p. 1235) provide the following figure:
Figure 1: A model of discourse as a strategic resource

It is was anticipated that for analysis of corpus two, this model would provide a useful framework for examining the ways in which organisational discourse both reproduces and transforms institutional structures (Parker cited in Hardy et al. 2000). In doing so it would be possible to establish how various organisational discourses produces ‘real’ effect with regard to international collaboration and communication. Organisational discursive activity is complex with many potential linkages that could enable or prevent collaboration, and it was thought that this model could provide a way of breaking down individual discourses to ascertain how the various players across the collaboration might engage with them.

Archaeology and genealogy

Foucault refers to his research methods as ‘archaeology’ and ‘genealogy’ although he does not provide an explicit guide to how to conduct such an analysis and thus the actual methods adopted by researchers vary. What is common to all, however, is the application...
of Foucault’s concepts of discourse/power/knowledge and therefore the lens through which they all read their data (Carabine cited in Wetherell, Taylor & Yates 2001). The approach utilised here takes what Foucault says about discourse/power/knowledge and combines it with perspectives on health research, organisational discourse and communication as a lens for interpreting the literature relating to international collaboration.

Carabine (cited in Wetherell, Taylor & Yates 2001) provides a guide to undertaking Foucauldian genealogical discourse analysis. The twelve step guide suggests topic selection, knowing your data, identification of themes, evidence of interrelationships between discourses, identification of discursive strategies and techniques employed, looking for absences and silences, resistances and counter-discourses, identifying the effects of the discourse and being aware of the limitations of the research as being important elements of the process. Carabine also refers to Context 1 (outline the background to the issue) and Context 2 (contextualise the material in the power/knowledge networks of the period).

“Archaeology describes discourses as practices specified in the element of the archive” (Foucault 1972, p. 140). Thus, archaeological analysis seeks to uncover discursive objects in time. They are described “for themselves”, Foucault (1972) writes, with no attempt to discern any deeper meaning around why something was said (or not said, as the case may be).

As Graham (2005) notes, for Foucault to have prescribed specific steps for the conduct of this analysis would have been hypocritical. However, although now prescriptive, Foucault was specific about the intent of his analysis. Therefore, here I provide my understanding of Foucault’s terms in order to provide some level of specificity about the methods used for the purpose of this study.
Discursive formations, objects, enunciative modalities, concepts and strategies

“Discursive formations are defined as much by what lies outside them as what lies within” according to Danaher, Schirato and Webb (2000, p. 35). Thus, collaboration as a discursive formation is defined not only by the act of collaboration, or by those who participate in collaboration, but by all those people and circumstances that influence, facilitate and inhibit attempts to collaborate. Collaboration in relation to health research is invariably a collaboration between universities or other educational facilities with hospitals and other primary clinical and/or community health settings. While they may be thought of as being constituted by physical buildings, they primarily involve relationships between groups and individuals and the discursive formations they create, enable and utilise.

The most obvious way to catalogue discursive formations would be to group together these serious speech acts which refer to a common object. Discursive formations produce the object about which they speak. Foucault stresses that the space in which objects can be encountered is not to be found by analysing the concepts of the object it forms: “These relations are not present in the object, it is not they that are deployed when the object is being analysed … they do not define its internal constitution, but what enables it to appear … to be placed in a field of exteriority” (Foucault 1972, p. 50).

Foucault hypothesises that it is possible to group statements based on different unities or similarities. However, it is their discontinuities, rather than their unities, that he becomes more interested in. It is the way in which statements are dispersed that Foucault refers to as discursive formations.

In order to understand or make sense of identified objects of discourse, Foucault looks for underlying themes. Here, he proposes that such themes are defined by their points of diffraction but that it is also important to understand that all possible alternatives may not
have been realised and the determination of the theoretical choices that were actually made (Foucault 1972).

**CODING FRAME DEVELOPMENT AND USE**

The coding frame was developed by working through a sample of the collected texts, which were read and re-read to establish themes and definitions of themes, thus identifying some initial objects of discourse. These were utilised as the baseline framework, which was further developed as the analysis progressed.

The discourses for *corpus one* were as follows:

**Modernisation:**
- Publish or perish
- Knowledge for development
- Re-imagining a new world
- Evidence based practice
- Global partnerships for global solutions

**Colonialism:**
- Superman syndrome
- The Cinderella effect
- Voices full of money
- Who is my brother’s keeper?
Methods

• The great 'brain' robbery

• A pocket full of power

The discourses for corpus two were as follows:

External:

• The whole world in their hands

• Competing with everyone from everywhere for everything

Internal:

• Balance of power

• Oneness and manyness

DATA STORAGE AND MANAGEMENT

It was anticipated that this research project would result in the retrieval of a large volume of data for each phase and it was necessary to consider utilising an electronic software package to manage this data. Opting to utilise computer-assisted qualitative data analysis software for the purpose of this research was taken very seriously and with due caution. As discursive approaches to data analysis do not lend themselves to automated processing, selection of an appropriate tool for the purpose of data management alone was challenging. There are many qualitative data analysis programs on the market, including but not limited to Nudist, Atlas /ti, N-Vivo or X Sight. However, my own experience led me to consider the Joanna Briggs Institute Thematic Analysis Program (JBI-TAP). This would be an exciting opportunity to trial a relatively new piece of software
and contribute to the body of knowledge around the utilisation of computer-assisted qualitative data analysis software as part of a discursive analysis of data.

While thematic analysis is not necessarily congruent with discourse analysis, JBI-TAP was considered an appropriate tool to utilise for data storage and management. The three-step process embodied in JBI-TAP involves the extraction of qualitative data (such as concepts, statements or text); categorising these extractions on the basis of similarity in meaning; and then organising these categories thematically to form representations of the data.

JBI-TAP was utilised to attach codes to particular pieces of text and then perform various subjective functions on the coded text. With the large amounts of data collected, JBI-TAP provided a convenient and powerful tool for automating the repetitive and time consuming administrative aspects of data analysis. However, it is important to note (as in Phillips & Hardy 2002) that in the case of discourse analysis, software is simply a way of automating and managing the subjective process of manual coding. It provides a framework for working through data, but does not improve the analysis in terms of the way in which the researcher explores multiple meanings and traces their implications, which remains an inherently subjective process.

ETHICS

There was no formal requirement for ethical approval, as the study did not involve the collection of data from human beings.
CONCLUSION

A Foucauldian informed method is a common undertaking due to the lack of a rigid, prescriptive process. Thus, frameworks provided by other authors and researchers are also considered in order to provide as clear a picture as possible of the activities undertaken for the various steps of the research process. While this piece of research is respectfully grounded within a Foucauldian perspective, it acknowledges and utilises the more pragmatic advice of other scholars in the field in order to interrogate and analyse the construction of various discursive strategies relating to international collaboration.
The Emperor’s new clothes: scepticism and clarity in international collaboration

“Science and art belong to the whole world, and the barriers of nationality vanish before them”

-- Johann Wolfgang von Goethe (in Zerhouni 2004, p. 1211)

SYNOPSIS

Dominant and competing discourses relating to international collaboration in this body of work encompass a range of perspectives, both positive and negative, but falling predominantly into two broad camps – that of a modernisation perspective and that of a colonialist perspective. While both recognise the potential benefits of international collaboration, it appears that strategies for how this activity is most effectively undertaken, and who actually benefits, within the field of health research are quite different. Partnerships between developed and developing country researchers were a particular focus of this body of literature and have existed for some time now in various capacities. This process of international collaboration is an extremely complex process, and its virtues and importance have been much debated in the extant literature.
INTRODUCTION

“The idea of two worlds of science, Kofi Annan writes, is anathema to the scientific spirit. It will require the commitment of all of us to change that, and to bring the full benefits of science to every part of the world” (cited in Krull, 2005, p. 120). The concept of a world citizen or of individuals possessing a global or international identity is clearly not new. For hundreds of years humans have transcended national and international boundaries.

As mentioned previously, the expression ‘citizen of the world’ has existed for some time now. In recent times calls for universal human rights and for transglobal solutions to problems such as environmental degradation and global warming has resulted in a landscape that, in many ways, tends to be more global than national. This is also true for health issues such as HIV/AIDS, Severe Acute Respiratory Syndrome (SARS), Influenza A virus subtype H1N1 and other whole of society pandemics that have gained international attention and sought international solutions.

The contemporary sociology of ‘citizenship’ has a direct impact on the existence of world and regional organisations and the ways they function together on the international stage. It seems that it is becoming increasingly important to establish strategies to combat international problems through collaboration. The challenge, however, is to establish effective strategies for collaboration. As Ansari, Phillips and Hammick (2001) suggest:

“If collaboration is to be successful in making a difference in the lives of people, then increasing the precision and context of appraising its effectiveness will reduce the nature of inconclusive evidence and is likely to improve the practice of partnerships, coalitions and joint working in health and social care.” (p. 215)
The public discourses related to international collaboration identified in this section provide interesting and valuable insights into the construction of the various elements that contribute to this challenging process. The discourses identified here are situated primarily within two theoretical perspectives, that of modernisation and (neo) colonialism. These perspectives provide a lens through which to view the challenges and enablers surrounding approaches to collaboration.

Modernisation theory, when applied in this way, is based on the belief that it is possible for equal development to be reached between developed and less developed countries. It is the transformation of traditional societies to modern societies through education and technology to spur economic growth. Conversely, colonialism involves the building and maintenance of colonies in one territory by people from another. Sovereignty is claimed and the social structure, government and economy are changed. It is characterised by unequal power relationships and dominance of one society over another.

Within this study, the term ‘neo’ colonialism is utilised to refer to the variety of things since decolonisation efforts after World War II. Generally it does not refer to a type of colonialism but rather colonialism by other means. Specifically, there is a relationship between the stronger and weaker ‘collaborators’ without the stronger country ‘building or maintaining’ a colony per se.

CORPUS ONE – EXTANT LITERATURE

This section of the analysis attempted to discover what discourses exist in the extant literature relating to the concept of international collaboration. Following Williams (2003), the analysis is informed by more than one theoretical perspective, affording the opportunity
to capture some of the complexity and the continuum of possibilities of the functional relationship between countries that collaborate internationally. Therefore, for the purpose of this study, the identified discourses are situated within two distinct perspectives, that of modernisation and neo-colonialism. As Williams (2003) states, both theories contribute different viewpoints to the investigation of international research because they lead to different conclusions about international relations and knowledge building.

The substance of these perspectives, neo-colonialism and modernisation, provide lenses through which to analyse the discourse of international collaboration and trace them on a continuum between mutually beneficial collaboration (consistent with modernisation) and exploitation (consistent with colonialism) as the following table by Williams (2003, p. 505) demonstrates:
Table 1: Continuum of cross-cultural collaboration

<table>
<thead>
<tr>
<th>Consistent with Modernisation ideals</th>
<th>Consistent with Post-colonial practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principles</strong></td>
<td></td>
</tr>
<tr>
<td>Self-representation</td>
<td>Representation</td>
</tr>
<tr>
<td></td>
<td>“Other” representation</td>
</tr>
<tr>
<td>Dialogue of difference</td>
<td>Categorisations</td>
</tr>
<tr>
<td></td>
<td>Dialogue of Hierarchies</td>
</tr>
<tr>
<td>All perspectives valued and presented</td>
<td>Value of contributions</td>
</tr>
<tr>
<td></td>
<td>Exclusion and de-valuing of perspectives</td>
</tr>
<tr>
<td>Re-distribution, shifting, interdependence</td>
<td>Power balance</td>
</tr>
<tr>
<td></td>
<td>Static, hierarchical, isolation</td>
</tr>
<tr>
<td><strong>Processes</strong></td>
<td></td>
</tr>
<tr>
<td>Equitable</td>
<td>Distribution of resources</td>
</tr>
<tr>
<td>Equal, inclusive</td>
<td>Participation</td>
</tr>
<tr>
<td></td>
<td>Dominated, exclusions</td>
</tr>
<tr>
<td>Balanced representation</td>
<td>Authority/Voice</td>
</tr>
<tr>
<td></td>
<td>Dominated representation</td>
</tr>
<tr>
<td>Equal dispersion</td>
<td>Distribution of benefit</td>
</tr>
<tr>
<td>Shared or newly developed symbols, meanings, practices</td>
<td>Development of culture</td>
</tr>
<tr>
<td></td>
<td>Application of one side’s symbols, meanings, practices</td>
</tr>
</tbody>
</table>

A small but relatively coherent number of both formal and informal texts were identified which contribute to articulating the discourses of international collaboration in health research. These are outlined in this chapter as follows:

Discursive perspective one: A modernisation perspective on international collaboration

- Publish or perish
- Knowledge for development
- Re-imagining a new world
- Evidence-based practice
- Global partnerships for global solutions

- Hallmarks of success

Discursive perspective two: A (neo) colonialist perspective on international collaboration

- Superman syndrome

- The Cinderella effect

- Voices full of money

- Who is my brother’s keeper?

- The great ‘brain’ robbery

- A pocket full of power

A MODERNISATION PERSPECTIVE ON INTERNATIONAL COLLABORATION

Modernisation theorists conceived of new nations in ways that “at least implicitly acknowledged that they were historically constructed and contingent, but their work generally treated these countries as natural units that would – or at least ought to – evolve along a single path (or at best a limited number of paths) towards modernity” (Berger 2003, p. 422). Essentially, modernisation theory assumes that all countries may reach the goal of a similar type of modern society.

Given that a significant proportion of the extant literature relating to international collaboration considered global relationships between developed and developing
countries, a modernisation framework for analysis of this discourse was deemed appropriate.

Thus, the first dominant discourse throughout the extant literature relating to international collaboration takes a modernisation perspective. Modernisation theories are focused on the contributions of industrialisation, science, technology, and cross-national contact to positive international allegiances (Tudjman cited in Williams 2003). The discourses here reflect a desire for jointly developed universal approaches, which have the potential to bring both economic and social benefits.

In both domestic and international settings, processes for the conduct of research and the development and utilisation of health policy are subject to constant review and change, influenced heavily in all regions by modernisation. Increasingly, the globalisation of these activities has seen a mobilisation of resources and attempts to collaborate internationally never experienced to this extent before.

Within this modernisation framework six ‘discourses’ were identified as follows:

- Publish or perish
- Knowledge for development
- Re-imagining a new world
- Evidence based practice
- Global partnerships for global solutions
- Hallmarks of success
Publish or perish

The concept ‘publish or perish’ refers to the pressure placed on those working in academia to publish work constantly in order to sustain their career. There is often a great pressure on scholars to publish new work frequently and frequent publication is still considered one of the few methods available to researchers to improve their visibility and thus assist in securing much needed funding, and tenured positions and/or promotions. It is, therefore, no real surprise to find a discourse relating to publication and authorship as a sign of the existence of, and justification for, international collaboration.

Pao (1992) recognised that, for the scientist, collaboration is a mechanism to advance research as well as a means to increase productivity and visibility. Their examination of co-authorship offered empirical evidence that collaboration is associated with research funding and is a means to advance research and multiply publication capacity for the productive members. Similarly, Narvaez-Berthelemot (1995) acknowledges that publication in international co-authorship often gives scientists in developing countries the opportunity they need for wider visibility.

Publication in peer reviewed journals is cited as greatly increasing the “visibility and acceptability of research in developing countries” and as a strategy for boosting chances for obtaining research funding (Harris 2004, p. 9). However, Harris goes on to note that English “scientese” is not the native language of every scientist, and there are challenges for developing country scientists in terms of identifying the right journal and constructing an article to meet the specific requirements of that journal. Thus, partnership with colleagues internationally would be beneficial in this respect.

Co-authorship was considered by a number of authors as being indicative of international collaboration. Leydesdorff and Wagner (2008) note a rapid rise in international co-
authorship during the 1990’s indicating a rise in collaboration. They go on to suggest that international collaboration in science can be considered as a ‘communication network’ different to national systems with its own internal dynamics.

According to Leydesdorff and Wagner (2008) there was a rapid rise in internationally co-authored papers, which they attribute to a rise in collaboration. This “dramatic” increase in collaboration continued to rise in the early 2000’s and they suggest that:

“... international collaboration in science can be considered as a communications network that is different from national systems and has its own internal dynamics. National systems have policies and institutions that mediate scientific communication, while at the global level the network exists primarily as a self-organising system.” (p. 317)

The authors of this paper believe that the landscape for competition and cooperation shifted, greatly expanding opportunities for ‘knowledge diffusion’ at a global level. This is seen as having particular benefit for those working at the periphery in terms of having access to the core group. At the same time, they state, the core group now has a greater ability to “access, absorb, and make use of participants from peripheral countries” (Leydesdorff & Wagner, 2008, p. 323). Thus, co-authorship and publication has mutual benefit for all involved. They note that developing countries in particular may find that, as scientific capacity continues to grow around the world, good ideas will “flow from their laboratories to the larger actors who are better able to publish these ideas in scientific journals” (p. 324) and that the benefits of science can be disseminated more effectively.
An initial mapping table of the literature included in this phase of the study was developed to provide an overview of the publications and other documents identified and included in the study for analysis, the origins of the authors and the year of publication.

**Table 2: International co-authorship of papers**

<table>
<thead>
<tr>
<th>Author</th>
<th>First author origin</th>
<th>Collaborators origins</th>
<th>Year of publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taylor, CE</td>
<td>USA</td>
<td>Single author</td>
<td>1976</td>
</tr>
<tr>
<td>Trostle, J</td>
<td>USA</td>
<td>Single author</td>
<td>1992</td>
</tr>
<tr>
<td>Pao, ML</td>
<td>USA</td>
<td>Single author</td>
<td>1992</td>
</tr>
<tr>
<td>Gaillard, JF</td>
<td>France</td>
<td>Single author</td>
<td>1994</td>
</tr>
<tr>
<td>Brohman, J</td>
<td>Canada</td>
<td>Single author</td>
<td>1995</td>
</tr>
<tr>
<td>Okuonzi, SA</td>
<td>Uganda</td>
<td>UK</td>
<td>1995</td>
</tr>
<tr>
<td>Narvaez-Barthelemot, N</td>
<td>Mexico</td>
<td>Single author</td>
<td>1995</td>
</tr>
<tr>
<td>Freyvogel, TA</td>
<td>Switzerland</td>
<td>Single author</td>
<td>1996</td>
</tr>
<tr>
<td>Maina-Ahlberg, B</td>
<td>Sweden</td>
<td>Sweden</td>
<td>1997</td>
</tr>
<tr>
<td>Raymond, SU</td>
<td>USA</td>
<td>Single author</td>
<td>1997</td>
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<tr>
<td>Walt, G</td>
<td>UK</td>
<td>Single author</td>
<td>1998</td>
</tr>
<tr>
<td>Hawkes, C</td>
<td>Australia</td>
<td>Australia</td>
<td>1999</td>
</tr>
<tr>
<td>Edejer, T</td>
<td>Switzerland</td>
<td>Single author</td>
<td>1999</td>
</tr>
<tr>
<td>Ettorre, E</td>
<td>UK</td>
<td>Single author</td>
<td>2000</td>
</tr>
<tr>
<td>Leatherman, S</td>
<td>UK</td>
<td>UK, USA</td>
<td>2000</td>
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<tr>
<td>Lee, K</td>
<td>UK</td>
<td>UK</td>
<td>2000</td>
</tr>
<tr>
<td>Salvage, J</td>
<td>UK</td>
<td>Single author</td>
<td>2000</td>
</tr>
<tr>
<td>Ansari, WEL</td>
<td>UK</td>
<td>UK</td>
<td>2001</td>
</tr>
<tr>
<td>Benatar, SR</td>
<td>South Africa</td>
<td>Single author</td>
<td>2002</td>
</tr>
<tr>
<td>Bhutta, ZA</td>
<td>Pakistan</td>
<td>Single author</td>
<td>2002</td>
</tr>
<tr>
<td>Arunachalam, S</td>
<td>Canada</td>
<td>Single author</td>
<td>2002</td>
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<td>Jentsch, B</td>
<td>UK</td>
<td>UK</td>
<td>2003</td>
</tr>
<tr>
<td>Author</td>
<td>Country</td>
<td>Authorship</td>
<td>Year</td>
</tr>
<tr>
<td>----------------------</td>
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<tr>
<td>Widdus, R</td>
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<td>2003</td>
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<tr>
<td>Williams, C</td>
<td>Canada</td>
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<td>2003</td>
</tr>
<tr>
<td>Robinson, D</td>
<td>USA</td>
<td>USA</td>
<td>2003</td>
</tr>
<tr>
<td>Gonzalez-Block, MA</td>
<td>Switzerland</td>
<td>Single author</td>
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</tr>
<tr>
<td>Williams, AB</td>
<td>USA</td>
<td>Single author</td>
<td>2004</td>
</tr>
<tr>
<td>Hubbard, T</td>
<td>UK</td>
<td>USA</td>
<td>2004</td>
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<tr>
<td>Ollenschlager, G</td>
<td>Germany</td>
<td>NZ, UK, Netherlands, Finland, USA</td>
<td>2004</td>
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<tr>
<td>Rolfe, MK</td>
<td>UK</td>
<td>UK, Sweden</td>
<td>2004</td>
</tr>
<tr>
<td>Shapiro, K</td>
<td>South Africa</td>
<td>South Africa</td>
<td>2004</td>
</tr>
<tr>
<td>Gray, M</td>
<td>Australia</td>
<td>Single author</td>
<td>2005</td>
</tr>
<tr>
<td>Swingler, GH</td>
<td>South Africa</td>
<td>South Africa, Greece</td>
<td>2005</td>
</tr>
<tr>
<td>Lucas, AO</td>
<td>USA</td>
<td>Single author</td>
<td>2005</td>
</tr>
<tr>
<td>Volmink, J</td>
<td>South Africa</td>
<td>Single author</td>
<td>2005</td>
</tr>
<tr>
<td>Krull, W</td>
<td>Germany</td>
<td>Single author</td>
<td>2005</td>
</tr>
<tr>
<td>Hooper, TI</td>
<td>USA</td>
<td>USA, Saudi Arabia</td>
<td>2005</td>
</tr>
<tr>
<td>Gonzalez-Block, MA</td>
<td>Mexico</td>
<td>Single author</td>
<td>2006</td>
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<tr>
<td>Shunemann, HJ</td>
<td>Italy</td>
<td>Norway</td>
<td>2006</td>
</tr>
<tr>
<td>Syed Sherriff, RJ</td>
<td>Colombia</td>
<td>UK, India</td>
<td>2006</td>
</tr>
<tr>
<td>Tugwell, P</td>
<td>Canada</td>
<td>Thailand, Swaziland</td>
<td>2007</td>
</tr>
<tr>
<td>Bourgeault-Tasse, I</td>
<td>Canada</td>
<td>Single author</td>
<td>2007</td>
</tr>
<tr>
<td>Kikuchi, S</td>
<td>Japan</td>
<td>Single author</td>
<td>2007</td>
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<tr>
<td>Capitulo, KL</td>
<td>USA</td>
<td>Single author</td>
<td>2007</td>
</tr>
<tr>
<td>Tucker, TJ</td>
<td>South Africa</td>
<td>South Africa</td>
<td>2008</td>
</tr>
<tr>
<td>He, ZL</td>
<td>The Netherlands</td>
<td>Canada, NZ</td>
<td>2008</td>
</tr>
<tr>
<td>Leydesdorff, L</td>
<td>The Netherlands</td>
<td>USA</td>
<td>2008</td>
</tr>
<tr>
<td>Katsouyanni, K</td>
<td>Greece</td>
<td>Single author</td>
<td>2008</td>
</tr>
</tbody>
</table>
While this does not necessarily provide a comprehensive overview of the literature regarding international collaboration, what was striking about this exercise was the number of single authored papers in this sample. Given that the focus of most of the papers was international collaboration, it was interesting to note so few papers were co-authored by anyone, let alone authors from another country. Even with the establishment of large international collaborative agencies with a particular focus on health research in the mid to late 1990’s, there is no substantial increase in the number of internationally co-authored papers relating to this topic.

It was also interesting to note, in an article by Hawes and Emden (1999) that there is a requirement of single authorship by some North American universities for promotion and tenure, which as they state, is entirely “counter productive to collaborative relationships” (p. 5). They go on to add that “In the case of authorship, power and self interest are disguised as status and prestige which, if threatened, can reveal the debilitating effect of collaboration: highly capable individuals devitalised by overt and covert power struggles over first authorship” (p. 5).

The number of first authors from developing countries also remains low even today. However, it is important to consider that many scholars and academics from these regions may have moved to the developed world and thus the proportion of those publishing or co-publishing may not be accurately reflected in this type of analyses.

The number of national or locally co-authored papers compared to the number of internationally co-authored papers is quite low, which is interesting given that the topic under examination in these papers is international collaboration.
Gaillard (1994) addresses the issue of publication as follows:

“Generally, developing country partners have been most active in the implementation of the research project, but less involved in the other phases, i.e., the planning of research and the dissemination of the research results. Scientists in the South tend to be more involved with the execution tasks (data collection, field experiment), whereas their partners in the North tend to be more responsible for the conception tasks ... As a consequence, it is not surprising that partners in the North tend to publish close to twice the number of papers, and present twice as many papers at conferences than their scientific partners in the South ...” (p. 57)

Gaillard goes on to advise that an important ingredient for successful collaboration is the joint development and authorship of scientific papers that include the names of the authors from both sides appearing on the published articles. The distinction in this paper between research assistance and research partnership is important. Co-authorship, in this sense, is indicative of an intention to recognise scientific communities in developing countries and to communicate collaborative efforts in symmetrical, complimentary, transparent and equal ways. Gaillard suggests that if true collaboration has in fact taken place that joint publication of the results of collaborative projects is simply the natural flow of events.

**Knowledge for development**

‘Development’ came in to the English language in the eighteenth century and was characterised as an extension of ideas related to biology and evolution (Watts 1993). As a field of study, development discourse was initiated in the 1990’s and fits well within the modernisation framework utilised here. It attempts to account for the idiosyncrasies of
Phase 1 - Results

local language and knowledge and to engender a joint approach to goal setting and task achievement in collaborative activities. The development discourse identified in this body of literature relates to local ownership of collaborative efforts. It utilises phrases such as ‘mutually beneficial’ and ‘capacity building’ among others.

Development is described by Watts (1993) as “a discursive field, a system of power relations, which produces what Foucault (1979) calls domain of objects and rituals of truth” (p. 265). He goes on to argue that the narratives around sustainability in development and health and global change are intrinsically linked with concepts of knowledge and power. This, in turn, impacts on pragmatic attempts to facilitate international collaboration.

Links to development discourse in this body of literature identify languages and practices associated with development as a process of modernisation and the role of international collaboration for health research in relation to this. Within this discourse, issues of appropriate technology, diffusion of innovation and the provision of aid to developing countries are covered.

Brohman (1995) states that traditionally, “Within modernisation theory, cultural factors such as ethnicity typically represented obstacles to development that were rooted in traditional societies and that were destined to disappear in the course of development” (p. 124). However, within the discourse represented here in relation to health care and health research on an international scale, the emphasis is on recognition of the uniqueness and inimitability of different cultures and a need to recognise such distinctive characteristics in order to ensure the meaningfulness and relevance of research and its outcomes.

Phrases such as ‘equality’ and ‘knowledge sharing’ are utilised throughout this discourse, placing significant power with those who may otherwise be deemed as powerless. For example, Hooper (2005) states, “International collaborations offer new perspectives and
important opportunities for health researchers to share information, experiences, and methods that can be the basis for population-based health studies of mutual interest" (p. 192). Similarly, Krull (2005) writes, “Without local knowledge and an understanding of the local problems and research needs we will not succeed in answering crucial questions of our common future” (p. 119).

Brohman (1995) states:

“Power has always been a central component of development; without it there is little that the popular majority can do to change their situation. Within Third World societies, the ‘professionalisation’ of development studies under exclusionary Eurocentric frameworks, the control of this knowledge by elites in their own interests, and the devaluation of alternative sources of popular knowledge have all prevented the majority from participating in centres of decision making power.” (p. 130)

However, within a modernisation framework the knowledge and interests of researchers in developing countries is placed at the centre of collaborative partnerships.

Concepts of diffusion of innovation were identified throughout the literature with third world/underdeveloped countries couched in terms of an innovation gap that the West offers to assist to fill. In conjunction with this is the idea that scientific collaboration can produce creativity and innovation that can be widely distributed around the world, expanding the “pool of talent that is available for tackling research problems” (Lucas 2005, p. 1). Lucas (2002) suggests that:
“The most successful examples of such partnerships confer clear benefits to both contracting parties, and eventually to scientific progress in general. In an ideal case, the partnership produces a smooth dovetailing of skills and expertise. The partner from the developed country contributes expertise as well as sophisticated laboratory and other special resources that are not available in the less developed institution. Their peers in the developing country provide local clinical and other contextual knowledge.” (p. 5)

Recognition of economic and socio cultural differences inextricably linked with diffusion of innovation and thus discourses about the role of international collaboration within a modernisation framework. Here the discourse calls for a rethinking or re conceptualisation of developing countries as passive recipients or beneficiaries of collaborative processes but rather as active participants who drive research agendas.

Appropriate technology is also a strong concept within this discourse of development. It can be defined as technology designed with due consideration of the environmental, ethical, cultural, social, political and economic aspects of the community it is intended for. With this in mind, the challenges for successful international collaboration in health research are many.

Taylor (1979) alludes to the utilisation of appropriate technology in an “evolving climate of international collaborative research” (p. 981). Almost thirty years on a report by the World Health Organization (2008) stated that, “the accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better educated and modernising global society” (p. 6).
It is believed that this “global stewardship” and intense exchanges between countries and sharing of knowledge around threats, challenges and opportunities will only contribute to enhancing international research agendas and improving global health outcomes.

Harris (2004), in a report describing her experience of conducting research in developing countries with local scientists, speaks of “technology transfer” whereby technology is broken down and re-constituted on site (p. 7). However, she notes that, “technology alone is not a magic bullet” and must be adapted where necessary and invented when indicated (p. 7). Similarly, Lucas (2002) refers to international collaboration as offering opportunities to strengthen research capacity in less developed economies and institutions as well as “facilitating the transfer of technology” (p. 3).

The development discourse here, within a modernisation framework, situates knowledge and power equally with both developed and developing countries. Much of this discourse dovetails a recognition that all societies have the capacity to modernise with concepts of mentorship to enable independent, sustainable and equitable growth.

Re-imagining a new world

There is considerable discourse around the utilisation of international collaborative partnerships to contribute to resolving what is now commonly referred to as the ‘10/90 research gap’. In 1990, the Commission on Health Research for Development estimated that only about 5% of the world’s resources for health research (which totalled a US $30 billion in 1986) were being applied to the health problems of low and middle-income countries, where 93% of the world’s preventable deaths occurred. Some years later the Global Forum for Health Research coined the term ‘10/90 gap’ to capture this major
imbalance between the magnitude of the problem and the resources devoted to addressing it.

Within a modernisation framework, this collocation of terminology regarding problem identification and knowledge sharing implies the enabling of considerable capacity building. This discourse relates to the benefits of international collaboration and is particularly optimistic about the promise of dealing with the health problems that affect poor populations in developing countries.

For example, Miranda and Zaman (2010) argue that large international collaborations are the only way to ensure that research is truly generalisable and accounts for different contexts such as the organisation of health care delivery, its human resources and financing. Further to this, they state that, “Regional differences can be a strength within a multi-national study, not a weakness if an appropriate plan of analysis is integrated early on in the design of the work” (p. 2). They see mutual benefit in such collaborations as not only addressing issues specific to developing countries, but also accessing untapped potential for research that contributes more generally by generating low cost solutions to broader health issues seen in rich countries, thus exporting “success from the poor world to the rich world” (Miranda & Zaman 2010, p. 3).

References made within the text to the gap between developed and developing countries in relation to health challenges and health research, for a large part, focused on the commonalities in challenges confronted and the scope for finding solutions through collaborative efforts internationally.

It is perspectives such as this that remind us of how the landscape of health research for development has changed over the years in several important ways. These changes relate to a significant increase in expenditure on health research, an increase in the
number of ‘actors’ engaged in health research across the world and a shift in the epidemiology of disease (both in terms of communicable and non-communicable diseases).

With these changes so too have the discourses around international collaboration evolved and strengthened around the mobilisation of resources to improve global health outcomes and close this gap. Lee and Mills (2000), both based at the London School of Hygiene and Tropical Medicine, believe that the consequences of this gap are profound with diseases affecting large proportions of humanity receiving comparatively little attention. Their belief is that much of the problem lies in how health research is governed. Fitting within the modernisation framework, they suggest that developing countries should not be seen as passive recipients of charitable handouts, but as partners in the production of health research to tackle major problems such as health inequalities, infectious diseases and changes in the environment.

Similarly, Bhutta (2002) a Professor in Pakistan writes that, “important steps in redressing this imbalance are to promote equity in health research globally and to strengthen the capacity within developing countries to undertake research that is relevant to them” (p. 114).

The expansion of international collaboration in health research, within this framework, is viewed as an important element for improving health outcomes, but it is argued that these new strategies should be “coupled with mechanisms for strengthening the research capacity in developing countries” (Lucas 2002, p. 4). Thus, the outcomes and benefits of such endeavours are deemed as being two-fold: improved health and improved capacity. The two are inextricably linked, as Volmink and Dare (2005) write:
“Inequalities in health research contribute to inequalities in health. If science is to live up to its promise to improve health and spur development, all countries should be able to participate in research. Collaborations in research ... may be one vehicle for strengthening research capacity in less privileged countries.” (p. 705)

Lansang and Dennis (2004) believe that for developing countries to “indigenize” health research systems, it is essential to build research capacity (p. 764). They state, “As a key element of capacity building, countries must also address issues related to the enabling environment, in particular: leadership, career structure, critical mass, infrastructure, information access and interfaces between research producers and users” (p. 764). It is here that they believe greater national and international investment in capacity building in developing countries has the greatest potential for securing “dynamic and agile knowledge systems that can deliver better health and equity, now and in the future” (p. 764).

Krull (2005) speaks of strengthening international collaboration in order to “develop the ‘African bench’ to improve responsiveness to African demands” (p. 119). He believes that through collaboration where scientists from developing and developed countries are brought together on an “equal footing” to “jointly explore” research topics and funding, true capacity building can be achieved (p. 119). The critical component to this strategy, in his eyes, is to a commitment to “listen to local voices” (p. 119). It is about creating talent for the region and maintaining it in its local environment using “symmetric” international partnerships (p. 120).
Evidence-based practice

Evidence-based practice has been the catchcry of the last two decades and its value is not lost on those who seek to collaborate internationally. The advent of international organisations such as the Joanna Briggs Institute and the Cochrane Collaboration have seen a significant increase in focus on the need to collaborate across borders to develop internationally relevant and meaningful guidelines for clinical practice. This in itself has sparked considerable debate around the reality of development and utilisations of guidelines in different, unique and inimitable contexts. Indeed, Ansari, Phillips and Hammick (2001) state that, “The dual demands of collaboration and evidence are becoming an integral part of many health and social care programmes” (p.216).

Pearson (1999) argued for a need to “further our international understandings of what it is to nurse effectively and with cultural sensitivity” in order to foster mutual support and respect among health professionals from different nations (p. 115). Pearson recognised that the situation of those working in Western developed countries differs significantly from those in the developing world and that an international exchange of ideas, views and research findings for the evaluation of clinical practice should be high on the agenda of the international community. Rolfe et al. (2004) also recognised the strength of this type of exchange across international borders, stating that to share experiences and knowledge can “provide evidence of what works and what does not – comparative experiences and analysis provide international collaboration with much of its power” (p.141).

Another international forum for the exchange of ideas, experiences and information related to evidence-based healthcare is the International Dialogue on Evidence Informed Action to Achieve Health Goals in Developing Countries (IDEAHealth). This international forum focuses on a small number of important health goals and brings together health policy
makers, researchers and citizen-consumers to share experiences and evidence in a bid to formulate solutions on how to respond to challenges like health human resources, maternal and child health and health financing (Kottow 2002).

Some would argue that evidence-based practice is not relevant to developing countries and that the majority of reviews published are of no use because of their Western focus. However, others have argued that “regardless of where one is located there is an ethical obligation to ensure that health care does more good than harm” (Volmink cited in Jordan 2009a, p. 7).

Collaboration between research groups in developed and developing countries to broadly facilitate the development of an appropriate evidence base and strategies for dissemination of the results of this research is believed, within this discourse, to be a fundamental relationship. As Jordan (2009b) states:

“Making the most of current relationships with groups in developing countries to grow the body of relevant health research evidence and make it accessible to professionals working in these regions is of paramount importance if we are to realise our goal of improving global health outcomes” (p. 15).

Nchinda (2002) stated, “Active promotion of evidence-based decision-making at all levels of the health field is a necessary step in the direction of improving the health of the population ... There is presently a mismatch between this increased disease and health burden and the technical and human capacity of developing countries to use existing knowledge to combat these diseases and health problems” (p. 1699). What is required, according to Nchinda, is the strengthening of indigenous research capacity, not only to address local needs and develop appropriate knowledge and relevant strategies, but also
to equip developing country scientists with the skills to translate the results of studies carried out elsewhere into their individual national setting.

Global partnerships for global solutions

The advent of globalisation has seen the development of discourses that encourage collaboration across global borders in order to resolve global issues. Health in particular has gained significant importance and profile on the international stage and is high on most political agendas. The global health landscape is constantly changing and in more recent times population growth, an ageing population, increased international travel and a myriad of pandemics and chronic diseases has seen unprecedented demands placed on health systems globally.

The philosophy behind a global approach to health related research is that more hands make lighter work, and that utilisation of research capacity across international borders will achieve quicker, more significant and more sustainable results. “In recent times,” writes Rolfe et al. (2004) “collaboration in research activities has become the watch word as institutions and organizations of all kinds in different geographical latitudes have found that they face common problems, so common solutions are tending to be sought” (p. 141). They go on to state that, “The rolling revolution of globalisation has brought into sharp relief the fact that many health care systems face universal challenges whilst often facing the same barriers in developing countries” (p.146).

Within this discourse, true partnership is valued where power is perceived as being equal between all participants. As Kofi Annan said (in Krull, 2005)
“What is needed is a true partnership of developed and developing countries – a partnership that includes science and technology. Cooperation among scientific and technological communities of different countries and regions yields a large collective reservoir of knowledge and expertise.” (p. 118)

Within this, physical, intellectual and technological resources are highly valued and sought after. Equally, all participants in the collaborative process are seen as having a contribution to make and, increasingly, collaborations and initiatives (such as the Scientists without Borders program or the Global Health program of the Bill and Melinda Gates Foundation) are being utilised to promote an international approach to the improvement of global health outcomes.

International partnerships are touted as needing to be just that: joint enterprises with equal input and tangible results. To this end, Lee and Mills (2000) state the importance of participants in developing countries not being seen as recipients of charitable handouts but as “partners in producing health research that is of high quality and tackles major problems such as health inequalities, infectious diseases and changes in the environment” (p. 775).

**Hallmarks of success**

Many of the authors in this body of literature identified ‘ingredients’ or ‘conditions’ for successful collaboration. While recognised as not being a ‘perfect’ science, this discourse identified common components that may contribute to building the foundations of frameworks to facilitate constructive collaborative working relationships. These ingredients often pertained to partnerships between developed and developing country researchers and groups. Gaillard (1994) identified conditions or requirements for successful collaboration that are common to most North/South partnerships.
Table 3: The Charter of North South Partners (Gaillard 1994, p. 58)

| The collaboration should be based on a strong mutual interest and both parties should have something to gain from it |
| Project proposals should, whenever possible, be drafted jointly and each partner should be associated as much as possible to the important decisions which need to be taken |
| In particular decisions on specific instrument purchase should be made jointly and the necessary provision for instalment, maintenance and repair should be secured |
| Provision should be made in the budget for a training component and research training should, wherever possible, take place as part of a formal degree program to increase commitment |
| Salaries should be sufficient to ensure a full time commitment, or completed by supplementary means (e.g. research honorarium) secured in the budget |
| Transparency should be a golden rule between the partners, e.g., both sides have information on the budget allocations to each side and how funds are being spent |
| Each cooperating group should include a substantial number of researchers (at least 3) |
| Both parties should meet regularly to review ongoing work and plan future activities |
| Communication channels (e.g. fax and email) must be available to secure efficient interaction between partners |
| Scientific papers should be written jointly, with the names of the authors from both sides appearing on the published articles |
| Collaborative programs should be evaluated on a regular basis, e.g. after each phase is completed. Monitoring should emphasise project outputs, rather than inputs |
| Mechanisms should be established so that the collaboration can continue after the collaborative program is terminated to ensure a long lifetime to the collaborative partnership |

Similarly, other authors also write of components that might constitute a successful collaborative relationship. Capitulo (2007) writes, “To build true partnership, it is important to identify the strengths of all participants and use these as the foundation for future work. Global collaboration in research is enhanced if goals are clearly defined and agreed upon and if partners commit to acknowledging the contributions that each partner will bring to project completion” (p. 1). Lucas (2005) also states:
“In an ideal case, the partnership produces a smooth dovetailing of skills and expertise. The partner from the developed country contributes expertise as well as sophisticated laboratory and other special resources that are not available in the less developed institution. Their peers in the developing country provide local clinical and other contextual knowledge. Contributions in kind from the host institution in the developing country compliment the financial donation from the developed partner.” (p. 482)

A (NEO) COLONIAL PERSPECTIVE ON INTERNATIONAL COLLABORATION

The production of discourse under conditions of unequal power is what has been referred to as the “colonialist move” (Escobar 1995, p. 9). Several of the discourses relating to international collaboration are governed by some similar principles to the colonial project in terms of creating an apparatus for one group to produce knowledge about and exercise power over another. It is implicit in expressions such as First World/Third World, Developed/Developing, or North/South.

Williams (2003) write that, “Post-colonial theories are the foundation of an alternative reading of international relations and research” (p. 504). Mishra and Hodge (cited in Williams 2003) suggest that this perspective, which has its roots in criticism of the colonisation that formed the Third World, provides an opportunity to conduct analysis particularly concerned with the cultural forms that are associated with “relations of domination and subordination within and between nations, races and cultures” (p. 504).
This ‘counter discourse’ to that of modernisation challenges the representation of developing countries as being equal and willing partners in the collaborative process and, instead, offers them up as being helpless and with nothing substantial to offer international collaborative efforts in health research. In this discourse, referred to here as a ‘neo colonial’ perspective on international collaboration, developing countries tend to be grouped together and treated as homogenous. In the extracts provided throughout this section, it is possible to see how a variety of discourses were pooled to produce a single discourse related to developing countries experiences of ‘control’, ‘exploitation’ and ‘paternalism’ when involved in international collaboration. This discourse is characterised by tensions that affect scholarly exchange and create global competition and control rather than collaborative partnerships in their truest sense.

Within this colonialist perspective six sub-discourses were identified as follows:

- Superman syndrome
- The Cinderella effect
- Voices full of money
- Who is my brother’s keeper?
- The great ‘brain’ robbery
- A pocket full of power

**Superman syndrome**

According to Foucault, knowledge and truth are inextricably linked with power. In fact, he proposes that knowledge and truth are *produced* out of power struggles and are used to legitimate the workings of power. Truth and knowledge, in this discourse, are seen as
being possessed by scientists from the developed world, sent to less developed countries to fight for goodness, justice and, most importantly, progress, and is referred to here as ‘Superman syndrome’.

The emergence of this discourse mobilises around the introduction of the Millennium Development Goals. This discourse collocates international collaboration with the improvement of global health outcomes and requires the efforts of developed countries to assist developing countries to eradicate particular diseases.

This discourse was originally situated within this research in the modernisation perspective, however, upon further analysis it appeared that it was a discourse that aligned ‘development’ with ‘dependence’ on aid or assistance from the developed world, constructing a discourse that represents developing countries as passive recipients of aid and not active or able to generate a better circumstance for themselves. As Jentsch and Pilley (2003) state:

“When Northern authors reflect on their experiences in North-South research partnerships, they tend to emphasise principles of partnership, such as ‘equality’, ‘capacity building’, and the ‘sharing of responsibilities’. However, structural inequalities exist which prevent the realisation of such ideals. Northern privileges persist, based on historical dominance over the South and continued economic advantage”. (p. 1957)

Thus, much of the discourse on this kind of capacity building in tinged with a subtle (and sometimes not so subtle) paternalism. This approach implies a ‘governing’ or ‘management’ of collaborative research relationships and, although the desire may be to
help, advise or protect, it neglects to provide for individual choice or personal responsibility and, in doing so, does less for ‘capacity building’ than it claims to.

Conventional assumptions around the notion of capacity building are challenged in this discourse. Unlike those seen within the modernisation perspective, within the neo-colonialist perspective this discourse capacity building is not necessarily beneficial to scientists in less developed countries. This is predominantly due to unequal power relations and the danger that the more powerful partners from developed countries could “exploit the vulnerability of the developing country scientists and institutions: perhaps focussing the research on priority interests of the sponsoring foreign institutions rather than on the urgent needs of the host country” (Lucas 2005, p. 482).

This discourse has interesting implications for concepts of local scientific expertise and developing strategies for international collaboration that work to develop self-sustaining improvements in developing communities. In essence, it suggests that the only possible strategy to eliminate diseases of the developing world is to adopt the science and technology offered through international collaboration. Jentsch and Pilley (2003) argue that, “It is the reality that none of the Northern partners are experts on culture and values in the Southern society (though they presume so), therefore there is a gap in ideas” (p. 1959). This neo-colonialist perspective is perpetuated by knowledge proprietorship and a lack of acknowledgement of individual contributions.

The Cinderella effect

Throughout much of the literature phrases such as ‘scientific colonialism’ and ‘imperialism’ appeared regularly. These terms have been deployed in a variety of ways to signify a set of critical perspectives on the nature and motivation of groups to collaborate with others
internationally. It is typified by the notion that knowledge is extracted and exported rather than being utilised to improve outcomes locally. Also referred to as “safari research” (Trostle 1992, p. 1323), or “parachute science” (Harris 2004, p. 9) it is said to have forced some countries to begin strictly enforcing regulations covering the exportation of data and creating an insular model for research that discourages international collaboration.

Jentsch and Pilley (2003) refer to the dynamics of this relationship as being like those represented in the European folktale of Cinderella and the Ugly Sisters, with the latter “using their advantage of wealth and position to exploit their step sister” (p. 1958). Their article describes situations in which agencies that provide foreign assistance and humanitarian aid can be identified as working to advance the political and economic interests of more advanced countries, particularly the United States. Within this discourse, capacity building, intellectual ownership and open exchanges of ideas and knowledge are deemed a fallacy. Rather, the ‘North’ is illustrated as possessing experts and the ‘South’ as requiring ‘capacity building’. It is very much an ‘us and them’, ‘providers and receivers’, ‘expert and novice’, ‘superior and inferior’ type of relationship that is articulated throughout this discourse. As Jentsch and Pilley (2003) articulate:

“Northern and Southern authors have evoked the terms Western imperialism, orientalism and (neo) colonialism for processes of indirect control exerted by the North.” (p. 1957)

Lucas (2002) describes the relationship between institutes established during the colonial era and local scientists as follows:
“Such institutes have the advantage of receiving stable financial support from the foreign government. They also attract scientists from the developed country who want to have research experience in developing countries. They also train local scientists but not all the foreign directors of such institutes commit themselves unequivocally to build a strong cadre of local scientists. In the past, they mainly used local staff in junior capacities – as bottle washers in the laboratories and as ‘fly boys’ in the field.” (p. 20)

Although Lucas describes this as a model for how the postcolonial transition can be used to good effect in remodelling and modernising institutions that were founded in colonial days it in fact is a discourse that strips developing country scientists of their power, devaluing their local knowledge and potential to contribute to the research program in a meaningful way.

Within this perspective the power is set firmly with the developed country. Williams (2003) refers to the “… persistence of Western domination of the international research agenda, exploitation of Third World nations for ‘exotic’ data sets, and enticement of Third World researchers to Western research centres leads some to describe modern international research as scientific colonialism” (p. 511). Similarly, Krull (2005) states:

“Medicine, and tropical medicine in particular, has at least to a certain extent always been imperialistic in nature, and today it is once again in danger not to resist contemporary imperialistic forces that hide under the folded veils of counter terrorism and corporate colonialism’. One could add ‘scientific’ and ‘educational’ colonialism.” (p. 118)
Voices full of money

In the Great Gatsby, F Scott Fitzgerald wrote that Daisy’s voice was “full of money” (Fitzgerald, 1925, p. 115). By this he meant that her voice had the tonal quality of having never known want, of having always been provided for, of being entirely educated. This discourse relates to resource dissemination and the allocation of funding and makes a clear distinction between those who have and those who have not. It places considerable power in the hands of those who have.

The challenge, according to Edejer (1999), is that, “Even the best intentioned funding agencies and developed country partners can exacerbate the poor state of local research environments by competing for the few qualified scientists in the country” (p. 440). The author argues that such agencies are driven by their own priorities and thus they offer chances for research collaboration, “which can bring in resources and prestige to the scientist and his base institution” (p. 440).

Similarly, Lee and Mills (2000) state that, “Each funding body tends to favor commissioning research themselves, rather than supporting research initiated by investigators; this makes it hard for some countries to set their own research priorities” (p. 775). Volmink and Dare (2005) also state:

“… the concept of international development aid trickling down to the poorest has not worked. Facilitating research partnerships that include the most disadvantaged groups will depend on targeted investments by the international community as well as by Africans.” (p. 705)

While the modernist perspective correlates international collaboration with increased opportunities for funding, the colonialist perspective sees developed countries funding
research (although it may be for the conduct of research ‘within’ developing countries or ‘to’ subjects in developing countries) that serves their own ends.

Who is my brother’s keeper?

Lucas (2002) expresses concern about some of the drug trials that pharmaceutical companies have sponsored in developing countries, which have not met high ethical standards. Accusations and complaints are outlined concerning the “exploitation of poor, uneducated individuals who have been exposed to drug trials without receiving full explanation of the procedures and without giving formal consent” (p. 9).

The notion of ethics is highly problematic. We live in a global community where notions of truth and what is considered ethical and responsible behaviour is highly variable from one country to another. There is no widely shared truth or ethical standard. Interpretations of what is considered moral and ethical behaviour can vary between individuals, communities and countries, and this was a prevailing discourse throughout the literature identified in this study. The juxtaposition of this discourse lies in whether the ethical standards of developed countries are applied to and applicable to the developing world. If they are applied, are they appropriate to the context and do they account for particular cultural nuances? If they are not applied, is this because researchers from developed countries are conducting their research abroad in order to avoid complex domestic ethical standards and processes?

Taylor (1979) asserted that tensions were becoming more acute internationally because “US ethical standards for research are not necessarily congruent with national customs and practices around the world” (p. 981). He goes on to add that there were all too many instances that could be described as exploitive, stating:
“The general charge has been that poor populations in developing countries were being used as guinea pigs and that some of the studies done would not be permitted in institutions in developed countries. Even more ubiquitous were accusations that scientists from developed countries engaged in ‘bleed and fly’ studies which used local scientists but gave them no credit.” (p. 981)

It seems that perhaps, since this statement was made in 1979, little has changed since with a more recent paper published some twenty years later stating:

“Though they are outwardly mutually beneficial partnerships, some of the new research practices and partnerships have more insidious, subversive ill effects, particularly for the developing country partner. Clinical investigations [result in problems] because of different and often conflicting cultural constructions of what clinical research is, how it is conducted, and what is to be gained from it.”

(Edejer 1999, p. 439)

There is a strong correlation here between ethical standards and treatment and power relations. Foucault (in Danaher, Schirato & Webb, 2000) argues that the practice of “an ethics” can be used as a technique for resisting oppression and power (p. 131). Within the colonialist perspective, however, enforced conformation to Western ethical standards acts to achieve the opposite within international collaborative efforts.

Taylor (1979) writes that, “Tensions are becoming more acute internationally because US ethical standards for research are not necessarily congruent with national customs and practices around the world” (p. 981).
Kottow (2002) argues that the scholarly exploration and endorsement of the “universalisability of ethics” rather than ad hoc development of arguments that allow for exceptions and variations from accepted moral standards would be far more beneficial to the international research community in the longer term (p. 24).

Rather than true international collaboration, this discourse sees the exploitation of poor and vulnerable communities and the “redefinition of equipoise to a more bland version, and denial of post-trial benefits to research subjects” (Kottow 2002, p. 24).

Hawes and Emden (1999) links the political dimension of collaborative research (defined by the authors as collaboration perceived as power relations) together with their ideas for an ethical dimension of collaboration. They state, “By ethical we mean the everyday sense of something being in accordance with principles of conduct that are considered correct. Our intention is not to try and conceive power as ‘good’ but rather, place power relations alongside another, ethical, element we consider necessary for effective partnerships: trust” (p. 8).

Edejer (1999) cites the Council for International Organisations of Medical Sciences, stating, “Researchers working in developing countries have an ethical responsibility to provide treatment that conforms to the standard of care in the sponsoring country, when possible” (p. 439). The addition of “when possible” at the end is interesting, implying that there may be circumstances where this is not possible and in such cases this practice would be acceptable.

Interestingly, Lucas (2002) suggests a progressive approach to ethics that recognises the considerable variability between the developed and developing countries may be appropriate. He suggests that, although more affluent countries may deem the “best standard of care” ethical, it would in fact be more ethical (as well as necessary, logical and
compassionate) to offer low-income countries “alternative, affordable and sustainable options” (p. 10). Taking this approach, it would in fact be unethical to offer standards of care that were not sensitive to local capacity and resource requirements.

**The great ‘brain' robbery**

Throughout the literature reference is made to the ‘brain drain’ from developing countries as a result of collaborative relationships. Brain drain entails the transfer of human knowledge, skills, experience and expertise from one area or region to another. Underlying this contemporary global issue is the legacy of colonialism. From times of slave trade, poorer communities were uprooted and their skills utilised to service those in developed countries. Colonialism devalues and dislocates traditional values and ways of living in the world.

This exodus of expertise from where it is so urgently required is considered a significant barrier to development and true international collaboration. The result is that, rather than capacity building in developing countries where it is most needed, scientific migration weakens research capacity and focus even further. As Edejer (1999) writes:

> “Internal brain drain occurs, and local expertise is diverted from the more important areas to the less important areas of research. A more insidious side effect is the developing country researchers work vertically with their Northern partners and become isolated from the other researchers within the country.” (p. 440)

In effect, developed countries end up ‘recruiting' researchers from developing countries, rather than facilitating the advancement of their expertise or growing the pool of researchers in these low-income economies. What has been termed as ‘traditional
collaboration’ on research projects has seen talented researchers attracted to Europe and the United States, where:

“... sooner or later they become detached from their original scientific and cultural environment and subsequently contribute to the unbalanced distribution of talent and research capacity between the North and the South. A self-sustaining system and a vicious circle – to the detriment of research in developing countries!” (Krull 2005, p. 118)

Rather than purportedly building capacity, cross-cultural collaboration is perceived within this framework as “draining disempowered groups of their research potential” (Williams 2003, p. 511).

Another example of this can be found in an article that appeared in the Economist (2008) related to the Gates Foundation and their impact on the conduct of research and priority setting. This article cites a letter from Arata Kochi, who said the excessive sway of the Gates Foundation was “distorting research priorities and quashing independent thinking by sweeping up the best scientists and keeping them ‘locked up in a cartel’”. The concern was that the Foundation was concentrating too much “glamorous science and long term technology bets”, rather than “putting boots of the ground in places like Africa”. Kochi added, “Gates can solve problems with money – but a lot of money leads to a monopoly, and discourages smaller rivals and intellectual competition”.

A Sydney Morning Herald article by Balakrishnan and Man (2007) also emphasize the problem of brain drain in international collaborative efforts. Quoting Charles Gore, author of a report into the matter, the authors state, “The problem of brain drain highlights the bigger issue of knowledge... The least developed countries have a huge problem... It is no
use just investing in human capital without policies which develop employment opportunities to encourage workers to stay."

In the article Mr Gore added that although aid to poor countries has been steady, the money is not being channelled to essential areas such as science and research, "Their economies remain locked into low value-added commodity production and low skilled manufacturing," he said.

"The departure of a large proportion of the most competent and innovative individuals from developing nations slows the achievements of the critical mass needed to generate the enabling context in which knowledge creation occurs. To favourably modify the asymmetric movement and distribution of global talent, developing countries must implement bold and creative strategies that are backed by national policies to: provide world class educational opportunities, construct knowledge based research and development industries and sustainably finance the required investment in these strategies." (Saravia & Miranda 2004, p. 608)

In order to understand brain drain at a global level and estimate the extent to which scientists born in countries with low opportunities never realise their potential, Ioannidis (2004) examined data on 1523 of the most highly cited scientists for 1981 to 1999, finding that “overall 31.9% of these scientists did not reside in the country where they were born” (p. 936). It seems that countries without a critical mass of native scientists lost most scientists to migration.

Further to this, Chandiwana and Ornbjerg (2003) state that, “Africa has scientists with skills to forge local and international partnerships, but the continent’s capacity to exploit this rich
resource depends on its ability to reverse brain drain and to create the necessary conditions for retaining those remaining at national research institutions” (p. 295).

It is interesting to note the discontent in the United States regarding international collaboration that followed the events of September 11th in 2001. With tighter restrictions being placed on those wishing to enter America, it proved harder for scientists from other countries to work there. What followed was outrage from the scientific community stating that this “stymied scientific collaborations” (Bhattacharjee 2009, p. 1377). Given that brain drain from foreign countries to locations such as the United States and other developed countries has been a significant discourse in the extant literature over the last few decades, it was interesting to locate this excerpt:

“The visa process became agonizingly slow in the aftermath of 9/11, when the government clamped down on anyone wishing to enter the country who had scientific and technical expertise deemed potentially useful to terrorists”.

(Bhattacharjee 2009, p. 1377)

This is an interesting sidenote as it has had the potential to threaten the status of the United States as one of the world’s leading scientific powers. Having been perceived as a dominant force in science and engineering for some decades, this disruption to the collaboration related discourse gives rise to interesting possibilities for collaboration with other nations.

A pocket full of power

Power was a recurrent theme throughout the discourses identified, but was also identified as a discourse in and of itself. Any analysis of the way in which scientific international collaboration emerged from the colonial crucible must account for those discourses relating
to knowledge and power, in the true Foucauldian sense. Referred to by Cooper and Stohler (cited in Watts, 1993, p. 261) as "tensions of empire", knowledge systems within a neo-colonialist perspective on international collaboration, relates to who is seen to ‘possess’ knowledge in the collaborative process.

Escobar (1995) refers to the production of discourse under conditions of unequal power as the “colonialist move” (p. 9), which entails specific constructions of the colonial/Third World subject in and through discourse in ways that allow the exercise of power over it. Within the colonialist perspective utilised here, power is situated with the coloniser.

Interestingly, within this discourse, although information is often collected in developing countries, knowledge is still perceived as being held by scientists in developed countries. It may seem an unremarkable distinction (information and knowledge) at first, but makes quite a difference to the ways in which power is conceived of and utilised. “Indeed,” writes Burrell (1988), “the petty malices of those who seek to dominate mean that knowledge itself is increasingly part of the play of domination” (p. 225). Thus, issues of power and knowledge are intertwined.

“Development,” according to Escobar (1995) “has relied exclusively on one knowledge system, namely, the modern Western one. The dominance of this knowledge system has dictated the marginalisation and disqualification of non-Western knowledge systems. In these latter knowledge systems ... researchers and activists might find alternative rationalities to guide social action away from economistic and reductionist ways of thinking” (p. 13).

Walker (2003b) writes comprehensively about collaborative process and the “semantic emergence of power” (p. 1). While there is a broad assumption that, even though collaborative partners may have unequal power bases from which to draw, the participants
will be equal within the confines of the collaborative project, Walker warns that this is often not the reality. She asserts that, “power structures develop in collaboration, not through positional hierarchy or resource dependency, but rather through a struggle over meaning” (p. 1). She believes that collaboration is not without a power structure, but that a power structure emerges through the constant struggle to define the collaboration. In this case, power is not attributed to those who possess the most resources, but by those whose “interpretations of reality are accepted by others” (p. 2).

This discourse related to the various power struggles faced in attempts to collaborate internationally, particularly where North-South collaboration was involved. It is also concerned with who ‘leads’ or ‘governs’ endeavours to collaborate internationally and whose needs are met through such endeavours.

“The state of global health research suggests that too often governance is not good. Imbalances in financial and intellectual resources between wealthy and poor have contributed to the latter being the subject of health research that primarily benefits the former.” (Lee & Mills 2000, p. 775)

Another notable mention of ‘information’, this time with a clear link to power constructs, comes from Arunachalam (2002) in a description about the increasingly important role of information and communication technologies (ICT’s) in the production, transmission and utilisation of knowledge:
“Thus the new ICTs, left to their own devices, will surely widen the knowledge divide or the disparities in people’s capacities to do science and technology and their ability to use them to their advantage. Thanks to men like Gandhi, Martin Luther King, Nelson Mandela and Desmond Tutu, we have abolished skin-colour-based apartheid, but are letting the new ICTs to create information-access-based apartheid.” (p. 16)

Arunachalam contends that while there is a desire to build up a research culture and adequate research capacity in developing countries the “transfer of basic knowledge and the development of opportunities for knowledge generation in developing countries continue to remain neglected” (p. 3). Hence, the advent of new ICTs will in fact ensure that the knowledge (and thus power) gap and disparities in research capabilities between developed and developing countries will continue to widen rather than close.

For the most part empowerment is considered to be a positive consequence of collaboration. However, the constructs of power and empowerment within the framework of colonialism may also work to serve a different end.

Foucault conceptualises the relationship between power and knowledge as an intersection in production of the human subject. To empower often implies a ‘granting of power’. For example, Ansari and Phillips (2001) write about empowering healthcare workers in Africa through partnership. The authors speak of shared power, the struggle for participation and the democratisation of decision-making. They perceive collaborative problem-solving as developing “human capacity and community leadership as participation builds the knowledge and skills of traditionally disenfranchised groups” (p. 235).
Conversely, empowerment may also be considered as a strategy to evoke a sense of powerlessness. This is particularly evident in the discourse that infers developing countries are passive recipients of aid in the collaborative process. Ansari and Phillips (2001) also acknowledge this unequal power play when they refer to the increase in problem solving capacity as strengthening a community’s ability to “interact with more powerful entities” and can contribute to the “competent community” (p. 235). These power disparities were articulated through sources of funding and restrictions on spending where approval had to be sought from the donor organization, perpetuating a feeling of inequality.

**DISCUSSION**

International collaborative relationships, whether they are concerned with health research or anything else, have been shaped by the emergence of discourses connected with technology, migration patterns, media forms, the movement of ideologies and values, flows of money across global financial markets, and trade in a variety of products. Some would argue that the most significant influence on these relationships has been a long period of Western domination and colonisation of other parts of the world. It can be argued that ‘colonisation’ and the ‘Postcolonial’ environment we are often described as living in today has had the greatest impact on the ways in which various organisations and individuals collaborate across international borders. Foucault was interested in the ways in which discourses “played a colonising role in ordering experience, making sense of these experiences and distributing people within these orders” (Danaher, Schirato and Webb 2000, p. 106).

The colonial perspective utilised within this study as a framework for analysis of the discourses within the extant literature reflects this. In these discourses, the research being
undertaken in ‘developing’ or ‘Southern’ regions was perceived as being done ‘to’ rather than ‘with’. As such, it placed subjects under surveillance. This discursive construction of developing country researchers as being incapable of conducting their own research without assistance and monitoring is evident throughout the literature. Utilisation of the word ‘developing’ itself implies that there is still progress to be made in these countries and posits researchers from these regions as being naïve, incapable, unqualified and in desperate need of the assistance of researchers from developed countries.

Foucault’s conceptualisation of ‘disciplinary power’ and ‘disciplinary technologies’ also comes into play within the discourses identified under the colonialist perspective. The goal of disciplinary power is to produce a docile person, or body of people, who can be controlled, dominated, transformed, used to the advantage of the controller under the guise of collaboration. Within the colonialist perspective, researchers in developing countries are perceived as being of use in order to advance the objectives and goals of researchers in developed countries.

Several discursive strategies can be detected as operating through the discourse of international collaboration in health research. These strategies fit nicely, although not necessarily neatly, within two distinct perspectives, that of modernisation and colonialism, which provide an interesting lens through which to examine the intricacies of international collaboration. These perspectives lead to very different conclusions regarding the potential benefits and burdens associated with international collaboration. There are also a variety of strategies and frameworks associated with concepts of successful collaboration.

While the literature is not necessarily this polarised it is interesting that much of the literature regarding international collaboration is associated with developed and developing or North and South divides. Associated with this are significant power and knowledge
related issues. Once again, the modernisation and colonialist perspectives provided the perfect lens through which to view these discourses.

Within the modernisation perspective, discourses empowered those in disadvantaged and vulnerable communities. International collaboration, in these cases, was about a relationship that ‘enabled’ and ‘facilitated’ research agendas that were of mutual benefit and fostered strengthened capacity for future development. Conversely, the colonialist perspective saw discourses surrounding the abuse of scientific researchers in low-income economies to advance endeavours in the developed world, placing all knowledge and power with those in the developed world.

Under the ‘colonial gaze’, researchers in developing countries are viewed as not having the experience, skills or knowledge to undertake useful and rigorous research without the assistance of foreign aid (be that financial or otherwise).

Heterotopia, Foucault’s concept of disposition and space relations, is also evident in the literature surrounding international collaboration under the colonialist gaze. The experience of heterotopia disposes people to wonder which world they are in. Within the discourses located in a colonialist perspective surrounding international collaboration in health research, this was demonstrated through the conduct of research by Western/developed countries using their own ethical frameworks and standards. This logic provided an impetus for controlling and regulating how research was conducted without acknowledging local ethical and cultural considerations. It is the very act of collaboration in these circumstances that brings two very different worlds into what can be considered open conflict as scientists from developed countries intrude on, or invade, less developed countries in order to conduct research and then leave. It is here that language such as ‘bleed and fly’ or ‘parachute research’ become most significant and noticeable.
Within this discourse, vapid and tokenistic displays of equal opportunity and benefit are forfeited in a reality of a Western predisposition to self-aggrandisement. This self-serving desire for increased power and academic domination (both in terms of intellectual recognition and the attraction of funding) was evident throughout the literature.

Through the analysis of this body of literature it is possible to make some assumptions regarding the ways in which the discourses were ‘deployed’ for a specific audience in order to perform specific tasks. Although the authors throughout the extant literature come from geographically and culturally diverse backgrounds, it appears that the audience for this body of work is very much the Western, developed, English speaking academic and scientific world. Regardless of perspective, be it modernist or colonialist, the messages throughout the discourses are relatively clear. That said, it was beyond the scope of this research to search more broadly for literature in languages other than English, which may have skewed this result if it were possible.

As Williams (2003) states, “the inaccessibility of their perspectives leaves a large question about their perceptions of whether they or the people of developing countries have benefited from this or other health collaborations” (p. 511).

An endogenous reorientation of approaches to international collaboration might be ideal, but is not necessarily realistic. While ‘in principle’ arrangements may be established where the research relationship is equal (in terms of intellectual property, contributions etc), there will always be one party that contributes more (be it financially or otherwise).
CONCLUSION

Although there are elements of the identified discourses that could potentially lead to successful collaborative relationships, there appear to be no conclusive strategies for successful collaboration in the extant literature. This may be due to the fact that the literature search did not seek to identify reports on collaborative research (as these tended to focus on the work rather than the collaboration) but papers that commented on the barriers and facilitators to international collaboration.

There are, however, a variety of broad principles for international collaboration, with specific reference to collaboration between ‘unequal partners’ to ensure a successful collaborative partnership that produces mutually beneficial outcomes. These include, but are not limited to, ethics, mutual knowledge sharing, and financial and technical support.

Ultimately, the oscillation between the modernisation and colonialist perspective seems not to have dissipated at any particular point. Looking at the genealogy of the literature examined, these perspectives received equal attention throughout and still do today. The discourses located within each perspective have significant consequences for the ways in which individuals and groups who collaborate across international borders make sense of, and experience, this type of relationship.

To this end, the evolution of these discourses brings us to our current nexus of past approaches and the necessity for a strategy to move forward.
Conflic, compliance and cooperation in collaboration

“The lightning-spark of Thought, generated, or say rather heaven-kindled, in the solitary mind, awakens its express likeness in another mind, in a thousand other minds, and all blaze-up together in combined fire; reverberated from mind to mind, fed also with fresh fuel in each, it acquires incalculable new light as Thought, incalculable new heat as converted into Action.”

-- Thomas Carlyle (1899, p. 11)

SYNOPSIS

Organisational discourse can be viewed as a play of differences in meanings mediated through socially constructed language practices. In this way, the production of collaborative relationships can also be thought of as a discursive construction. A discursive analysis of collaborative processes enables a closer examination of how relationships and understandings are produced, negotiated, formed and re-formed to bring collaboration into being and to make it sustainable. Traditionally, literature regarding organisational strategy has been largely quite distinct and separate from literature regarding organisational discourse. However, distinct and definitive links can be made between the two that can be used to identify carefully constructed activities designed to shape organisational identity, communication and collaborative functions. Such an
Phase 2 - Results

approach enables an exploration of how discursive action is embedded within broader frameworks of understanding, communication and interaction, and utilised to bring about strategic change.

INTRODUCTION

While phase one drew on concepts identified in the international literature relating to collaboration, phase two grounds these concepts in a case study that demonstrates how discourse might constitute a strategic resource in the promotion of an international collaborative approach to evidence-based health care. In such a way, discursive activity can be used to generate new, or access existing, discourses to enact various communicative and collaborative organisational strategies.

Hardy, Lawrence and Grant (2005) suggests that “Organizations in all sectors of society increasingly are becoming involved in a variety of collaborative arrangements, alliances, partnerships, roundtables, networks, and consortia - in order to promote innovation, enter new markets, and deal with intractable social problems” (p. 58). They go on to add that “by collaborating, organizations hope to leverage the differences among them - in terms of knowledge, skills, and resources—so as to develop innovative, synergistic solutions to complex problems they cannot solve on their own” (p. 58).

However, in examining organisational discourse, Boje, Oswick and Ford (2004) argue that it is an unrealistic and untenable position to treat an organization as a site of “monological coherence and univocal harmony” (p. 571). There is always more than one possible reading of any organisational literature, event or situation. Thus, the information presented in the following chapter is prefaced with a ‘statement of influence’ regarding the stories,
conversations and other materials and texts utilised for the identification and construction of discourses in this setting. They have been produced and reproduced, distributed and redistributed for consumption and reconsumption across discursive divides. They have then been interpreted by the researcher who was also involved in the production of some of the texts analysed.

Power, discourse and collaboration in organisations

Discourse analysis is utilised increasingly in studies of organisations and collaboration. It provides an opportunity to explore the richness and diversity of organisational experiences and influences and for making sense of organisational phenomena. So too does it provide an opportunity to examine the social constructions of different groups and the ways in which they interact with each other across and within those groupings. For Lawrence, Phillips and Hardy (1999), the communicative process underlying collaboration is a “discursive struggle between different groups of stakeholders each with access to different sets of discursive and non-discursive resources” (p. 486). These discursive struggles and tensions contribute to building and defining relationships within the collaboration and providing ways of understanding each other and working together. These discourses require a context, which is sometimes internally driven and at other times drawn from external sources. In the case of collaboration within evidence-based health care, it is important to first look at the movement itself and how collaboration fits within it as a discursive framework.

The ‘new religion’: evidence-based practice on the world stage

As Fairclough and Wodack (cited in Hardy et al. 2000) suggest:
“Discourse is not produced without context and cannot be understood without taking context into consideration ... Discourses are always connected to other discourses that were produced earlier, as well as those which are produced synchronically and subsequently. In this respect, we include intertextuality as well as sociocultural knowledge within our concept of context.” (p. 1233)

Similarly, the discourse around international collaboration in the case of the Joanna Briggs Institute took place within (and also helped to shape) the broader discourse of evidence-based health care. The discourse of international collaboration, in this case, is co-located within the discourse of evidence-based health care and even more acutely, situated within the even broader discourse of medicine and nursing.

As Salvage and Smith (2000) state, “The relationship between doctors and nurses has never been straightforward. The differences of power, perspective, education, pay, status, class, and – perhaps above all – gender have led to tribal warfare as often as peaceful coexistence. Nurses’ readiness to be slighted and doctors’ reluctance to be challenged create an undercurrent of tension” (p. 1019).

This undercurrent of tension and power dynamics is no less apparent within the discourses surrounding evidence-based health care. As Professor Alan Pearson, Founder and Executive Director of the Joanna Briggs Institute stated in an editorial the year after the Institute’s inception:
“Although the evidence-based practice movement continues to have a largely medical orientation, the usefulness of the approach for nursing practice is increasingly being recognised. Although nurses are central to health service delivery in most health systems, and account for a large portion of purchasing expenditure and salary costs, researching nursing effectiveness and using the results of such research in practice has yet to become a widely accepted norm.” (1997a, p. 145)

In the same year, he wrote of the need to “develop evidence-based nursing within a multidisciplinary context and to ensure that nursing continues to be regarded as a central service in health care delivery” (Pearson 1997b, p. 22).

While Walker (2000) would agree that nurses needed to find ways of better explicating practice and its effect on patients she would go on to add that it was necessary to find ways of doing this that were “consonant with our history as a profession comprised mostly of women working in a patriarchal culture where we came to believe its versions of truth before we were able to explore what truths we had of our own” (p. 17).

Winch, Creedy and Chaboyer (2002) address this issue in their Foucauldian analysis of nursing governance and the rise of evidence-based practice. The authors place evidence-based reviews as discursive mechanisms that present nursing practice as an “intelligible field” (p. 158). Indeed, the article cites the Joanna Briggs Collaboration as a supporter of evidence-based nursing and midwifery. They also utilise Foucault’s notions of governmentality to conceptualise the systematic review as “a technique of government developed from the fields of medicine and statistics” (p. 157). By placing nursing along
side medicine they attempt to legitimise nursing ‘science’ as the dominant way of knowing. Interestingly they state:

“Nurses, having dispensed with the quantitative vs. qualitative debate to embrace multiple sources of knowledge including that derived from intuition, are now faced with returning to a purely scientific model of knowledge construction.”

(p. 159)

In such a way, they construct an identity that appears to follow the medical lead, stating further that, “one of the most appealing aspects of evidence-based nursing must lie in its ability to tap into the highest form of accepted contemporary authority, science. In this way,” they go on to add, “nursing is being placed on a level playing field alongside other health professions seeking a scientific base. For nurses (and many other healthcare professionals) this powerful new direction is somewhat at odds with a tradition of ritual and ‘art’ with a smattering of science” (Winch, Creedy & Chaboyer 2002, p. 159).

The evidence-based movement (and the Cochrane Collaboration in particular) have frequently come under considerable criticism, although not always too serious, with a tongue-in-cheek humorous article that appeared in the British Medical Journal in 2002. The article likens the evidence-based movement to religious movement, “complete with a priesthood, catechisms, a liturgy, religious symbols, and sacraments” (CRAP 2002, p. 1496). The article makes specific reference to the Cochrane Collaboration and its use of the term ‘Cochranites’, referring to them as “members of a worldwide order that has Archie Cochrane as its patron saint. They worship systematic reviews” (CRAP 2002, p. 1498).

It is a language that seems to be absent in the other two major internationally recognised organisations, the Joanna Briggs Institute and the Campbell Collaboration. It seems that
the Joanna Briggs and Campbell Collaborations are slightly less zealous in their approach, with neither organisation referring to the ‘members of their order’ in such a way. That said they are equally enthusiastic about their worship of their ‘God’ (evidence). What differs is how they define it, with Cochrane and Campbell traditionally taking a much more limited stance on what is considered as evidence and the Joanna Briggs Collaboration believing in a broader and inclusive definition.

The evangelical tone of ‘joining’ or ‘belonging’ to an evidence-based organisation such as the Cochrane Collaboration, Campbell Collaboration or Joanna Briggs Institute is evident across the board. Indeed, the aforementioned humorous British Medical Journal article, published by authors who were in fact part of the Cochrane Collaboration, warns crusaders about “retaliation from the grand inquisitors in the new religion of EBM” (CRAP 2002, p. 1496). This crusade-like discourse is similarly reflected in an article by Holmes, Murray, Perron and Rail (2006) who refer to the “Cochrane Group’s disciples”, accusing the group of having a sense of entitlement and a “universal right to control the scientific agenda” (p. 185).

The competing discourses around evidence-based practice, particularly for the nursing profession, continue in an article by Walker (2003a). This polemic tackles political and professional questions about evidence-based practice, presented as a hand-me-down from the medical profession. Interesting, the Joanna Briggs Institute makes an appearance in the article with the author having attended the Institute’s first Colloquium in 1997 in Adelaide.

The following footnote about Professor Alan Pearson, Founder and Executive Director of the Joanna Briggs Institute appears in Walker’s 2003a article:
“Professor Alan Pearson is almost single-handedly responsible for inaugurating the EBP movement in nursing and midwifery in Australia (and indeed, now, across Australasia). His status as the first professor of nursing appointed in Australia is also significant in that he commands a very high profile both here and internationally. The authority accrued to his status over the years in part affords the profile of EBP greater currency and purchase on the collective imagination of the profession, than might otherwise be the case.” (p. 147)

Equally, Walker (2003a) says of Archie Cochrane:

“Dr Archie Cochrane is, of course, the man whose name is now lent to perhaps the most prominent marker of the EBP movement, the Cochrane Collaboration. Such a symbolic and material signifier of status and significance affords EBP enormous prestige and indeed medicine has often used its high profile performers to accrue authority and legitimacy to its ideas and practices in this (literally spectacular) way.” (p. 147)

Walker (2003a) asserts that evidence-based practice is dangerous and seductive, and states, “Nursing has long struggled to claim a legitimate voice for itself in the aggressively professionalising rhetoric of all healthcare practitioners. We are finding ourselves ‘following in medicine’s footsteps’ once again by embracing EBP in the way we have” (p. 153).

Holmes, Murray, Perron and Rail (2006) in their deconstruction of the evidence-based movement, accuse the Cochrane Collaboration, among others, of fascism and of creating a hierarchy endorsed by many academic institutions that serves to, “(re)produce the exclusion of certain forms of knowledge production” (p. 180). They go on to add that,
“Because ‘regimens of truth’ such as the evidence-based movement currently enjoy a privileged status, scholars have not only a scientific duty, but also an ethical obligation to deconstruct these regimens of power” (p. 180). This article caused (and continues to cause) significant debate and discourse around the evidence-based movement and its true value and contribution to health and clinical decision-making.

While it still has its critics, debate around the value or otherwise of evidence-based nursing, and indeed evidence-based health care generally, seems to have dissipated to a certain extent, with the focus now predominantly on how to teach the skills of evidence-based practice (from critical appraisal to evidence implementation and utilisation) to health professionals across the board. The prevailing discourse appears to be that evidence-based practice is substantively here to stay and is of significant value in context. Thus, its value lies in its use as a resource utilised along side other forms of knowledge (including clinical experience and client preference) in any given unique and inimitable health setting, which can vary form unit to unit, hospital to hospital, state to state or country to country.

As Day (2009) expresses so eloquently, “expert nurses are infinitely adaptable in their responses to unfolding situations at hand because they are able to engage in situated, context driven reasoning that shifts between the general and the particular …” (p. 482). No doubt that can be said of health professionals across the board.

Although this analysis does not seek to establish the merits or otherwise of evidence-based health care, it is important to contextualise the discourse of international collaboration in this way in order to understand how the discourse of the Joanna Briggs Institute relates to, is influenced by and contributes to the broader discourse of the movement itself, the desire to collaborate internationally and discursive strategies for achieving this.
For Foucault, the self is a historical and cultural phenomenon created through discourses that include practices. Foucault (cited in Winch, Creedy & Chaboyer 2002) suggests that, “Active fashioning of the self involves adopting practices of the self that do not originate from the individual but are suggested or imposed within a culture or social framework via codes and behaviours” (p. 157). In such a way, the discourses identified in this chapter in relation to international collaboration have required nursing and allied health groups to adopt (and in fact adapt) certain practices through the deployment of particular discursive strategies. The organisational discourses utilised as a strategic resource by the Joanna Briggs Institute are analysed here as a case study of the practice of international collaboration within this broader context.

**Discourse as a strategic resource**

As described in Chapter 4 of this thesis, Hardy, Palmer and Phillips (2000) outline a model of how discourse can be mobilised as a strategic resource and explore how discursive action is embedded within broader frameworks of understanding, communication and interaction. This model was applied to the discursive analysis for this phase of the study.

Organisational literature was utilised to examine an individual case of international collaboration. As such, documents including international committee of directors’ minutes, annual reports and strategic plans were identified and discursively analysed using methods informed by Foucault and Hardy, Palmer and Phillips (2000). This chapter will describe the results of the discursive organisational case analysis. It identifies and describes the dominant and competing discourses over the course of the organisation’s life span relating to international collaboration with regard to definition and strategies in practice.
This phase demonstrates the discursive construction, deconstruction and reconstruction of identity with regard to the concept of international collaboration within evidence-based practice for nursing and the allied health professions. This, in turn, enabled a more comprehensive understanding of how the Joanna Briggs Institute was situated or positioned internationally and, over time, how it was able to discursively shift how it was perceived internationally – thus enabling international collaboration. It explores the use of discourse as a strategic resource and identifies the ways it can be used to create and change organisations by invoking different discourses and changing meaning.

CASE IN POINT: THE JOANNA BRIGGS INSTITUTE

The organisation examined for the purpose of this study was the Joanna Briggs Institute, which was established in 1996 with the remit of improving global health outcomes through the synthesis, transfer and utilisation of evidence to inform clinical decision-making. Funded initially through the Royal Adelaide Hospital Research Foundation and the South Australian Health Commission and based at Royal Adelaide Hospital in South Australia, the Institute was linked to seven other centres in Hong Kong, New Zealand, New South Wales, Queensland, Tasmania, Victoria and Western Australia (JBI Annual Report 1997).

The original proposal sought to establish a Collaboration consisting of centres across Australia and New Zealand. As the Institute’s ten-year history states, “International collaboration and forging global partnerships was at the forefront of Alan Pearson’s mind from the very beginning” (Jordan, Donnelly & Pittman 2006). In fact, Pearson (cited in Jordan, Donnelly & Pittman 2006) who is founder and Executive Director of the Institute stated:
“When I wrote the original proposal I envisaged an Institute with Collaborating Centres around the world. It was an opportunity to make an impact on global health outcomes in a meaningful way. International collaboration would ensure that the process would be context driven by individuals and groups who understood their very specific health care environments and the forces that would work both for and against them.” (p. 17)

This statement became increasingly important as this phase of the current research progressed as it became apparent that it would once again be necessary to define ‘collaboration’ in order to be able to identify it in the organisational literature. The ‘practice’ of collaboration within the context of this research and indeed within the context of this phase of the research, could be defined in multiple ways and it was important to establish some concepts (if only peripheral concepts initially) in order to be able to analyse what was notionally considered to be the ‘data’ for the discursive analysis.

As the Institute expanded into international markets it was important for it to strategically position itself for new markets. This required significant discursive activity around several key areas of operation. Specifically, the Institute would need to consolidate its reputation as a leader in the evidence-based health field and consider broadening its scope of activity (i.e. multidisciplinary). It was important for the Institute’s communication strategy to start to reflect these key elements in order to create opportunities to collaborate more broadly with various interest groups across the world. This had to occur both internally as well as externally and thus a range of organisational documents was selected for examination in this phase of the project.
Foucault (in *Discipline and Punish* and *The Birth of the Clinic*) referred to ‘judicial gaze’ and ‘medical gaze’ respectively, which he explained as being derived from those professions so that those conferred with ‘qualifications’ by agents of the gaze can say things that other people believe without question. Similarly, the Joanna Briggs Institute had to discursively position itself as having qualifications, authority and reputation in order to create ‘buy in’ from key and potential stakeholders, whether they were members or centres. Thus, discourses created and utilised by the Institute to position itself in such a manner had to be ‘taken up’ in order for them to be effective.

It is here that the proposed model by Hardy, Palmer and Phillips (2000) makes it possible to focus on the discursive activities of the Joanna Briggs Institute and their effects, primarily, on its relationship with the Joanna Briggs Collaboration, although it is clear that there are some broader effects also.

The Institute initiated several external discursive activities by making a series of discursive statements around the perception of the Institute as a global leader in the evidence-based health care movement and as an international and multidisciplinary organization. However, there were also clearly identifiable internal discursive activities initiated through discursive statements related to internal activity such as establishing leadership through various power struggles and tensions and the discursive creation of a collective identity. Many of these statements were inter-discursive in that they introduced new discourses both to and about the Institute and its collaborating entities.
EXTERNAL DISCURSIVE ACTIVITY

The discursive activity identified here relates to the establishment of the Joanna Briggs Institute as an international and multidisciplinary world leader in the evidence-based health care movement. The Institute itself predominantly initiated this discursive activity in order to create opportunities for international collaboration. It was necessary to discursively leverage the profile of the Institute in order to gain a foothold in the evidence-based marketplace, and position itself as a desirable organisation to work and collaborate with.

Two dominant discourses were identified in the external discursive activity with several sub-discourses within each as follows:

- The whole world in their hands: discursive construction of the Institute as a global leader in evidence based healthcare
  - Methodological development
  - Evidence utilisation
- Competing with everyone from everywhere for everything: discursive construction of the Institute as international and multidisciplinary
  - Multi-disciplinary expansion: the new tribalism
  - International expansion: relations among nations

The whole world in their hands: discursive construction of the Institute as a global leader in evidence-based health care

The discursive positioning of the Institute as a world leader in evidence-based health care is a significant discourse, particularly as there was a desire to collaborate internationally
from the outset. If international collaboration was to be a reality, the Institute first had to establish its standing as a leader in the field of evidence-based health care. This would be a challenge given perceptions at the time of the evidence-based movement, particularly in relation to nursing.

“At this time many academics in the nursing profession believed the Institute was selling out nursing and pandering to medicine. Behind this hostility were two interlocking beliefs. First, it was assumed that evidence-based practice belonged in the domain of medical research. Second, as far as medicine was concerned, systematic reviews only admitted quantitative measures such as the randomised controlled trial as evidence and dismissed qualitative research as valueless” (Jordan, Donnelly & Pittman 2006, p. 22).

The discursive activity here related to introducing nursing as a legitimate contributor to the evidence-based health care movement. Although evidence-based practice was a familiar concept to those both inside and outside of the organisation, the Institute needed to establish a ‘voice’ of its own. It needed to make discursive statements regarding its activity that established it as being a unique and meaningful contributor to the movement in ways that other existing contributors could not.

The Institute had to demonstrate that it had something unique to offer and therefore discursive activity focussed on two main differentiating factors: methodological development, recognising the need for approaches that accounted for qualitative research as a valid form of evidence to inform clinical decision-making, and pragmatic strategies for evidence utilisation, connecting nursing academia and practice.
The power dynamics between the medical and nursing professions was an interesting influence on the discourse at this time. Conservative perspectives steeped in a long history of subservience and authority represented challenging discourses for an Institute that sought to establish itself as an equal player in the evidence-based movement. Another was the historical legacy of nursing and its culture that has sustained reliance on tradition, ritual and intuition while devaluing research-based evidence. These views were not going to be easy to transform, but the Institute would have to utilise a variety of discursive strategies in order to achieve the change they desired and needed if they were going to be able to work with others on the international stage.

“\textit{The idea of establishing nursing as a driving force in the evidence-based practice movement was contentious to say the least. Within the movement, battling the continued perception that nursing was a facile subordinate to the medical profession meant the Institute would need to work twice as hard for recognition; advancement in methodology and effective use of available technologies were therefore critical to its success.}” (Jordan, Donnelly & Pitman 2006, p. 39)

A variety of mediums were utilised to demonstrate the Institute’s capacity for leadership in this area. For example, in 2008 an advertisement was placed in The Weekend Australian that described the Institute as “Australia’s #1 global exporter of knowledge” (The Weekend Australian, p. 20). Advertisements such as these, placed by the Institute, contributed to both the discursive enhancement and solidification of the Institute’s position as a world leader in the evidence-based movement.
It is also important to note the increased use of the Internet during this time as a universal communication medium and a vehicle for enhancing international profile. The Institute relied heavily on its website to disseminate content to a large number of receivers and to discursively establish itself as an international entity (e.g. use of ‘org’ versus ‘edu.au’ for JBI COnNECT). The linguistic constructs and examples utilised on this site provided great insight into the broader power relations between the Institute, its Collaborating entities and the broader community.

In order to position the Institute internationally as a leader in the evidence-based movement it would be necessary to differentiate it from other like organisations. However, credibility would take time to establish.

**Methodological development**

The evidence-based movement has been much criticised, with proponents of the movement accused of ignoring the context of clinical practice and of ‘cookbook’ practice that focuses too heavily on the results of quantitative research or that evidence-based practice is ‘second rate science’ (Estabrooks 1998, p. 17). Traditionally the randomised controlled trial was held up as the gold standard for evidence-based practice and from the outset the Institute began to make discursive statements that indicated its uniqueness in this area. It quickly identified that the exclusion of qualitative evidence was seriously detrimental to evidence-based clinical decision-making for nursing. The Institute’s broader, more eclectic approach to what ‘counted’ as evidence was a milestone in its discursive development.

At the time the Institute was initiated, Kitson (1997) cautioned that:
“nursing may embrace the evidence-based movement without fully understanding the rules. And as written at the moment, the rules are about medical diagnosis, single clinical interventions, RCT’s and meta-analysis… there is a limit to nursing evidence conforming to these criteria. What must not happen is that nurses are then excluded from the movement because their research is too poor or insufficient in rigour or size”. (p. 38)

At the same time, Pearson (1997a), Founder and Executive Director of the Joanna Briggs Institute, wrote:

“The diverse origins of problems in nursing care practices require a diversity of research methodologies and a great deal of current nursing research is grounded in approaches which value qualitative data and the use of interpretation. The emphasis on randomised controlled trials in the evidence-based practice movement has been criticised by many nurses, though little of this criticism is evident in the literature. From a nursing perspective, the selection of research studies for systematic review needs to be eclectic enough to incorporate both classical medical and scientific designs and the emerging qualitative and action oriented approaches from the humanities and the social and behavioural sciences.” (p. 145)

However, criticisms of evidence-based practice for nursing pervaded and opinion remained divided as to its relevance and benefit to nursing practice. Upton (1999) stated, “The present principles of evidence-based practice threaten to continue to exacerbate the theory-practice gap by the recognition that some principles and beliefs underpinning the
concept are in direct contrast to contemporary nursing opinion and subsequently limit the practitioners' creativity and autonomy” (p. 554).

Professor Pearson published an article in the Institute’s publication JBI Reports titled, ‘Balancing the Evidence: incorporating the synthesis of qualitative data into systematic reviews’ in 2004. The article discussed what counts as evidence, particularly for health professionals, for achieving clinical effectiveness and outlined the Institute’s approach to the synthesis of qualitative evidence. The article references the Cochrane approach and its focus on quantitative evidence, discursively placing the Institute alongside the Cochrane Collaboration with regard to methodological development.

Although the article was published in an Institute publication and was criticised in evidence-based practice circles for reading as an advertorial for the Institute’s software program, it served to position the Institute as an organisation with a unique approach to qualitative synthesis and succeeded in generating discussion about the approach (Porritt 2009, pers. comm. 29 Nov).

Within the broader context of evidence-based health care, the Institute’s broad views of what constituted evidence for clinical decision-making began to warrant voice as the narratives they were creating began to have meaning for health professionals across the board.

In the years that followed, the Institute also became involved in the Cochrane Qualitative Review Methods Group, which would further leverage its identity and position it to discursively influence qualitative review methods and enact change. It was at this point that previous discursive activity resulted in concepts embedded in a larger international discursive context, resulting in a circuit of performativity. These new discursive statements consolidated and reinforced the Institute’s ‘power’ within the evidence-based movement.
The discursive activity surrounding the Institute as a global leader within the evidence-based movement resulted in broad change with regard to defining the evidence base, as well as participation and empowerment of those involved, particularly raising the profile of nursing within the field. It also worked to reaffirm the Institute’s ‘privileged’ position as a leader (both within the Collaboration and as a leader in evidence-based health care). The discursive circuit of connectivity is clearly evident in a recent article that appeared in a journal relating to the Institute’s approach and international relevance to practice and care:

“Whilst the conduct of Cochrane reviews of the effects of well defined interventions on equally well defined outcomes plays a role in evidence-based midwifery, it seems timely for us, as midwives, to become active in conducting JBI reviews of the effectiveness, feasibility, appropriateness and meaningfulness of the complex activities midwives and women collaborate in during childbearing. We need to do this because midwifery is far more than a constellation of interventions designed to achieve defined outcomes; it is about being with women in its fullest sense. In order to accelerate our aspirations to be an evidence-based profession I am interested in working with other midwives, with research qualifications, to forge a program of JBI-type reviews on par with the already high involvement of midwives in the Cochrane Pregnancy and Childbirth Review Group. In this way we can build the knowledge base for the discipline of midwifery. Enhanced midwifery knowledge will be counter to the tyrannical use of evidence-based medicine. Armed with evidence women and midwives will be more empowered to practise in the ways that they decide are the safest, most acceptable and most meaningful.” (Fahy 2008, p. 2)
The Institute’s status as a global leader in evidence-based health care can also be seen in the first chapter of the Joanna Briggs Institute history (A short history of a big idea, Jordan, Donnelly & Pittman 2006), which situates the Institute with an introductory chapter about the Cochrane Collaboration. The chapter places the Institute alongside organisations such as Cochrane, the Campbell Collaboration, the National Health Service (NHS) Centre for Reviews and Dissemination (CRD) in the United Kingdom and the Agency for Healthcare Research and Quality in the United States.

However, it also goes on to differentiate the Institute from these other organisations (which are based on the Cochrane model) stating, “Today, the Joanna Briggs Institute remains the only organisation in the world actively involved in the synthesis, transfer and utilisation of evidence for clinical decision-making” (Jordan, Pittman & Donnelly 2006, p. 6).

In order to raise the international standing and recognition of the Institute on the world stage it was also important to discursively position it alongside other similar (and internationally recognised) organisations such as the Cochrane Collaboration. In initial developmental years significant time was spent differentiating the Institute from these organisations, but in more recent years the Institute has been able to align itself with Cochrane and Campbell while maintaining its individuality.

**Evidence utilisation**

It was not only methodological development that set the Institute apart from other similar organisations. Its approach to the pragmatics of evidence-based practice was also a significant discourse as it worked to establish itself as a leader on the world stage. This was most evident in the distribution of its flagship publication *Best Practice*. This occurred
initially through its distribution in various national and international journals and early feedback was positive:

“I am happy to report that I have discovered a model of good practice in the promotion of evidence-based nursing and midwifery practice. The Joanna Briggs Institute for Evidence-based Practice in Australia produces and circulates, at regular intervals, information sheets about evidence-based practice, to foster safe practice … I have read a recent issue of Best Practice devoted to ‘Falls in Hospitals’ (the Joanna Briggs Institute 1998). It is excellent … The presentation and distribution of Best Practice in Australasia is a model of good practice in the promotion of evidence-based practice in nursing and midwifery. Other continents should follow their lead … I commend the publication of Best Practice and the fine work of the Joanna Briggs Institute and its collaborators to readers of the Journal of Advanced Nursing.” (Smith 1999, p. 1027)

In these early days, discursive activity was not restricted to publication of the sheets, but was enhanced by explanatory articles related to various issues around evidence-based practice, such as the systematic review process, measuring its impact on health outcomes and its role in the conduct of primary research (Wiechula 1998; Metcalf 1998; Evans, Kowanko & Hodgkinson 1998). By co-publishing these articles along side the Best Practice series, the Institute was able to discursively place the information sheets within a broader context and enhance their applicability to the evidence-based movement for clinicians to create ‘buy in’. Certainly, the dissemination of the sheets, which provided “readily digestible, and accessible”, evidence-based information was considered “timely” (Hunter 1998, p. 35).
Competing with everyone from everywhere for everything: discursive construction of the Institute as international and multidisciplinary

The discursive positioning of the Institute as international and multidisciplinary was another important discourse in the development of opportunities for international collaboration. There was a significant opportunity for the Institute here as the dominant discourse in the evidence-based literature related to medicine. There were few opportunities for other health related disciplines to engage with the evidence-based movement.

According to Sirkin, Hemerling and Bhattacharya (2008), part of today's global reality is that everybody is trying to “grab the same things that everybody else wants” (p. 3) – including collaborators. Like all ‘challengers’ in an industry, the Joanna Briggs Institute needed to establish itself as having something to offer that other similar collaborations could not. In this case, it needed to identify with international markets that required evidence for practice.

‘Collaboration’ enables challengers to make the great leaps forward they need to bring themselves into the contest. Thus, opportunities for knowledge building and sharing are placed high on the agenda for those wishing to break into international markets. Gathering knowledge of what people need, what resources are available and what limits constrain their choices is important for international expansion, and the most effective and efficient way for the Institute to do this was to collaborate with groups across the world. Therefore, collaboration in and of itself was utilised here as a strategy to provide the Institute with the international footprint it required.

In 2001 the Institute was still largely considered an Australian nursing endeavour. Leslie (2001) cites “the Joanna Briggs Institute in Australia, and Cochrane internationally” as providing “resources for nurse clinicians to practice EBP” (p. 91).
The discursive activity utilised by the Institute to demonstrate its multidisciplinary and international identity occurred through internal organisational documents as well as external communication mediums such as the local and international press.

The media can be a useful discursive tool for businesses attempting to create a niche for themselves and, in the case of the Joanna Briggs Institute, it was certainly more than an advertising medium. The media was utilised to assist in the creation of discourses that demonstrated the Institute’s international reach and influence in this area, and the appearance of advertisements and other stories in the international media was perceived as an important strategy for framing and presenting this.

There are several important considerations that should be brought to bear around the development of the public discourses presented in the media at this point and their significance to the broader discursive placement of the Collaboration. The Institute itself is based in Adelaide, South Australia and thus distance was an important influencing factor. Physical travel to other parts of the world was expensive and time consuming and so effective utilisation of other communication mediums was vital to a relatively new voice on the international stage.

The discursive activity identified in the media and other organisational documents can be broken down into several circuits of activity. These relate to multidisciplinary expansion and international expansion respectively.

*Multidisciplinary expansion: the new tribalism*

The name of the Institute itself contributed to the broader positioning of the Institute in the evidence-based movement. The Joanna Briggs Institute for Evidence Based Nursing was originally named after the first matron of Royal Adelaide Hospital. The purpose for this
was two-fold as it aimed at maximising the international reach of the Institute, rather than
giving it a geographical name, and reflecting the nursing focus of its work. In 1998
‘midwifery’ was added to the name following a request from the Western Australian Centre
Advisory Group to better reflect the focus of the Collaboration’s activities. In 2001 the
name was shortened to ‘The Joanna Briggs Institute’ to reflect the increasing
multidisciplinary nature of the work being undertaken.

Although the Institute was established in 1996, it was not until 2001 that there is any record
of advertising placement in newspapers, journals or other publications. Interestingly at this
time a story appeared in the local Adelaident and the accompanying photo was of a nurse
in a laboratory. The inclusion of this photo is interesting as a discursive representation of
how not only nursing, but also research, was perceived at the time. ‘Bench research’ was
something that the broader community could identify with, but systematic reviews were a
more obscure phenomenon (not only to the general public, but to the nursing and allied
health community at the time as well).

The discursive positioning of the Institute as multidisciplinary was also evident in the call
for new centres in allied health in 2002 (including physiotherapy, occupational therapy,
dietetics, medical radiation and podiatry).

The Australian Centre for Evidence Based Nutrition and Dietetics based at the University
of Newcastle and in collaboration with Central Coast and Hunter Area Health joined the
collaboration in 2003. Its aim was to “promote dietetics as a clinical science and to support
evidence based nutrition practices across the disciplines” (Jordan, Donnelly & Pittman,
2006, p. 31).

The Centre for Allied Health was launched on the 26th of August 2003. The media release
published by the Centre at this time described the venture as being “the first of its kind in
the world” (Grimmer 2003). The release went on to quote Director Associate Professor Karen Grimmer as saying, “This represents a major opportunity to put South Australia on the map internationally in allied health academic, teaching and clinical practice” (Grimmer 2003).

The discursive circuit of connectivity is nicely demonstrated in an editorial that appeared in the *Collegian* (2009), which discussed the Institute as “a major international multidisciplinary player in evidence-based practice and policy” (White 1999, p. 100).

*International expansion: relations among nations*

By the end of the Institute’s first year of operation it had Collaborating Centres located across Australia and in New Zealand and Hong Kong. Having firmly established these initial Centres, international expansion became a focus and several discursive strategies were employed to fulfil this remit. What would prove most challenging would be to convince potential international partners that a group in Adelaide, Australia was worth collaborating with given the status of Australia on the world stage. The extent to which this status is refracted through relationships with the United States and United Kingdom is an important consideration when examining the discursive strategies employed within this section of the analysis. Australia is still considered a ‘junior ally’ on the world stage and this is reflected in other international organisational relationships. It was therefore necessary for JBI to embed international expansion in the organisational discourse, as there was a core belief that this expansion would assist in providing the required foothold in international markets.
The developed world

The years 2001 to 2003 were characterised by dramatic growth in the Collaboration, particularly in Australia and the Pacific region. The first reference to the Institute as an “international collaboration” in the media occurred in an advertisement in the *Weekend Australian* in 2002. The call for expressions of interest to establish centres for evidence-based practice in health care specified that groups were required in Australia, Singapore, Japan and Malaysia, but that additional expressions of interest from other countries would also be considered.

Much of the discursive activity related to the international expansion of the Joanna Briggs Collaboration occurred through presentations and links with other international organisations. In 2003, Professor Pearson embarked on an international lecture series, which inspired several more groups to join the Collaboration (Jordan, Donnelly & Pittman 2006, p. 33). This lecture series saw Professor Pearson giving presentations in Spain, the United Kingdom and it also gave him the opportunity to make strategic links with groups such as the Nursing International Collaboration for Evidence Based Implementation Research into Guidelines (NICEBIRG), which facilitated links between guideline development programs in Canada, the Dutch Institute for Healthcare Improvement, the Scottish Intercollegiate Guidelines Network (SIGN) and the Nursing and Supportive Care National Collaborating Centre of the National Institute for Clinical Excellence (NICE) in England (JBI Annual Report 2002-3).

Most media references initially talk about the Institute as “Australasian” and with a “nursing and midwifery” focus. As a result, considerable effort was made to include Collaborating centre locations throughout the media and promotional literature in order to promote the international nature of the institute and its collaboration.
The Institute made the most of its internal publication, *PACEsetterS*, first published in 2004 to articulate the international nature of the Institute’s activities with stories from Thailand, South Africa, Scotland and America as well as Australia. The discursive activity within this publication alone relating to the international scope of the Institute and its collaboration was significant. It discursively places itself as an international identity in the first issue with a story simply titled ‘This is JBI’ (Porter 2004). This story describes the evidence based movement as being the “central point of healthcare systems internationally” (Porter 2004, p. 53). This issue of the magazine also includes a section titled ‘Worldwide links of the JBI’, listing collaborating centres in nine countries. The inclusion of a section titled ‘JBI world news’ also helps to discursively place the Institute on the international stage.

From the second issue of this publication a page was included that was dedicated to the ‘expanding JBI collaboration’ listing all of the centres all over the world. This strategy was again aimed at demonstrating the international nature of the Institute.

In a 2005 interview Dr Nick Allcock from the Nottingham Centre in the United Kingdom stated, “The links the school has developed through the Joanna Briggs Collaboration contributes to the school’s and the University’s international partnerships” (Jordan 2005, p. 47). In response to whether or not a JBI collaborating centre in the United Kingdom was necessary he states, “Our discussions with local practitioners have identified that the model of collaboration between JBI collaborating centres and their practice colleagues is highly valued by practitioners. The centre also looked forward to collaboration with other centres in the UK.”

The second issue of *PACEsetterS* included a story titled ‘New JBI links with China and US’ (JBI 2004a). In this story the international expansion of the Institute is once again addressed. It states that the link with the People’s Republic of China is “the first bond of its
kind between the countries and coincided with the Institute forging collaborative links with the United States, in New Jersey, Oklahoma and Indiana” (p. 6).

The United States market was always going to be a challenging one to break – particularly from Australia. Even in 2005, the readiness of nurses in the United States for evidence-based practice was still in question. Pravikoff, Tanner and Pierce (2005) stated that American nurses did not “understand or value research and have received little or no training in the use of tools that would help them to find evidence on which to base their practice” (p. 40). The establishment of three Joanna Briggs Collaborating Centres in the United States at this time was thus a major coup and a significant achievement. The international press was quick to pick up on stories related to the establishment of these centres, reflecting the respect and prestige with which the Institute was regarded.

The first mention of the Institute as an international leader in evidence-based nursing practice appears in United States newspaper *The Times* in a story about the opening of a Collaborating Centre at Purdue University Calumet. The story quotes Peggy Gerard, nursing school dean, as saying the collaboration will bring the school “international respect as a leader in state of the art nursing practice” (Eaken 2005).

In 2006 an advertising feature article appeared in *The Advertiser* that hailed the Institute as an international research institute recognised as “one of only three organisations in the world at the forefront of the evidence-based movement” (p. 46).

Another advertising feature in *The Australian* (2006) discussed the international impact of the Institute stating that the international network meant “... Institute members benefit from the research conducted not just here, but also by all the other Collaborating Centres across the world” (p. 5). The article goes on to discuss the work being conducted in
several Joanna Briggs Collaborating Centres specific to their local context, including the Australia Centre for Evidence Based Nutrition and Dietetics work on childhood obesity, the Hong Kong Centre for Evidence Based Nursing work on helping nurses search for information on SARS and the South African Centre for Evidence Based Nursing and Midwifery work on HIV/AIDS.

PACEsetterS editorials consistently make reference to the international nature of the Institute and its work, thus discursively and very intentionally, sending the message that this was not a colloquial or Australian-centric organisation. One editorial stated, “I find one of the most inspiring facets of the Institute is the international interest that is generated by the information produced and the subsequent widening circles of collaboration” (Court 2005, p. 4), while another, two years later said, “Working with the Joanna Briggs Institute I am reminded how our world is connected. While there are certainly many differing issues in different countries, many health issues remain the same” (Court 2007, p. 4). The language utilised here was very deliberate and consciously focussed on sending a specific and calculated message.

Once again it is interesting to note the use of the ‘.edu.au’ versus ‘.org’ in website development. The decision was made to utilise .org due to perceived external perceptions of the relevance of the Institute’s materials to overseas markets and the need to establish a site that would be appealing to health professionals and others across international borders. This, in itself, represents a discursive strategy to adjust international perceptions and ensure the international marketability of the Institute on the world stage.
The developing world

All of the discourses and discursive strategies mentioned above make the assumption that everyone, everywhere has access to everything – not so on the information super highway. Health workers in developing countries still have poor access to the information and resources they require in order to function adequately. Thus, if the Institute was to truly service these regions it would have to position itself to be able to do so.

While the term ‘developing’ is contentious, the first JBI Collaborating group from an emerging or developing economy (as classified by the International Monetary Fund's 'World Economic Outlook Report', 2010) appeared in South Africa. The Centre was officially launched in 2004 as the only collaborating centre in Africa, with a focus on providing evidence to inform care relating to diseases such as HIV/AIDS, malaria and tuberculosis.

Other entities were to follow, with the World Health Organization providing funding to groups in Kenya, Ethiopia, Ghana, Malawi and Nigeria and the Institute itself sponsoring groups in Camaroon, Rwanda, Uganda and Tanzania. This work was once again profiled in the Institute’s internal magazine, PACEsetterS, but also in other external publication such as The Independent Weekly. These articles served to create a discourse that highlighted the Institute’s interest and activity in this region and to align this work with the Institute’s mission of improving global health outcomes.

The Joanna Briggs Foundation was established in 2009 to further facilitate collaboration with those working in developing countries. It was important for the Foundation to align its communication strategy with that of the Institute and for the discourse around working with those in developing countries to be consistent if it was to be effective.
The carefully considered and cautiously structured discourse of the Foundation was aimed at creating a dialogue with Western audiences relating to supporting the work of the Institute in developing regions. However, it was important that this dialogue related to something tangible that the message recipients could relate to and connect with. Thus, a message strategy was developed that would strike a cognitive, affective and behavioural chord with audiences.

The most notable shift in the discourse relating to the Foundation was in the tagline, from “Creating healthier lives” to “Ignorance kills, knowledge transforms”. This shift was primarily aimed at creating a discourse that was more closely aligned with the work of the Institute and the aims and objectives of the Foundation. It also more closely aligns with guidance from the World Bank Group and World Health Organization, which emphasise the importance of sharing knowledge and recommend the adoption of policies to reduce knowledge gaps separating rich countries from poor.

**INTERNAL DISCURSIVE ACTIVITY**

The two dominant discourses here related to establishing the Institute as being the coordinating body for the Collaboration while maintaining a collective identity. These discursive statements initiated a circuit of activity designed to position the Institute internally as the ‘leader’ of the Collaboration. The narratives constructed as part of these discourses facilitated relationship building, and the tensions and paradoxes located in these discourses moved the Institute in very specific directions.

As with the external discursive activity, the internal discursive activity fell into two broad discourses, with several sub-discourses as follows:
Balance of power: discursive construction of the Institute and Collaboration as separate but related identities

Oneness and manyness: discursive construction of a collective identity

- Shared challenge
- Shared language
- Complete conversations
- Personal relationships

Balance of power: discursive construction of the Institute and Collaboration as separate but related identities

The discursive positioning of the Institute as being separate from the Collaboration was an important development, and several tensions and paradoxes in the discourse were quickly identified. Collaborations, according to Walker (2003b) are not absent a power structure; rather, that power structure emerges through the constant struggle to define the collaboration. She goes on to say:

“Power in collaboration lies not in directly controlling the behaviour of individuals, but rather in defining/creating a situation that constrains and enables individuals. The question now becomes how the organisational members arrive at this common understanding ... Power is generally operationalised as centrality and its correlate, prestige. Whether the network is based on communication, exchange of resources, or less tangible relationships such as affect, the actor who is at the centre of the network is considered to be the most powerful.” (Walker 2003b, p. 2)
The discursive statements identified here utilised both language and imagery to create a circuit of activity designed to establish the Institute as being separate from the Collaboration.

Discursive practice involves not just speech acts or written text, but also imagery, which is particularly important for this phase of the analysis. The discursive positioning of the Institute as a lead centre versus an Institute with Collaborating centres was a significant organisational discourse over the course of the Institute’s development.

In the 1997 JBI Annual Report, a ‘hub and spoke’ model was utilised to demonstrate the relationship between what was then termed the ‘Lead Centre’ in Adelaide and the other centres involved in the collaboration. This model positioned the Institute at the centre and collaborating centres around the outside.

![Figure 2: 1997 JBI organisational structure](image)

The report describes the Institute as an “international research collaboration with headquarters located at the Royal Adelaide Hospital, South Australia and representation in
all Australian States, New Zealand and Hong Kong” (p. 8). It goes on to state that most of
the infrastructure is housed in Adelaide with collaborating sites being linked in
electronically and through meetings.

The 1999/2000 JBI Annual Report saw the inclusion of a separate 'management structure'
in addition to the hub and spoke graphic to demonstrate this relationship.

**Figure 3:** 2000 JBI organisational structure

The graphics utilised in this report were accompanied by the following text:

“The Joanna Briggs Institute for Evidence Based Nursing and Midwifery
(JBIEBNM) is controlled by the Board of Management. The Director manages
the daily operations of the collaboration and operations of the collaborating
centres are managed by their Centre Directors.” (JBI 2000, p. 5)
At this time the Adelaide office is referred to as the coordinating ‘headquarters’. What is interesting about the addition of the separate graphic is that, while in the hub and spoke model the ‘lead Centre’ in Adelaide remains in the middle of the graphic, within the management structure, the Director is placed above all centres (including Adelaide). This graphic remained, although with some minor alterations, until the 2001/2002 Annual Report when a revised hub and spoke model was included with the Institute at the centre and members on the outside.

**Figure 4:** 2002 JBI organisational structure

In 2006 the JBI History book presented an organisational structure with the Institute at the base, followed by collaborating centres, networks and members.
Graphic representation of the relationship between the Institute and its collaborating entities remains a challenge even today due to the complex dynamics between the groups, as discussed below.

As mentioned, initially the South Australian Centre was referred to as the ‘Lead Centre’ – for the purpose of promoting a collaborative approach to the work being undertaken rather than having one centre ‘in charge’. This discourse continued for some years. In 1998 ‘draft regulations’ were introduced (working rules and conditions for Collaborating Centres of the JBIENBM), which described the relationship between the Institute and Collaborating Centres as follows:
“Although the Institute is coordinated nationally from the Adelaide site, its operations focus on the collaboration of individual country or state based centres for evidence based nursing and midwifery with the Adelaide site serving as the state centre for South Australia. Training, consultancy and research activities are managed by the country/state based collaborating centres, with the Adelaide office acting as the coordinating headquarters and providing a range of collaborating wide services to facilitate the promotion and development of evidence based nursing, following the “hub and spoke” approach to coordinated collaboration.” (JBI 1998, p. 18)

At this time the Centre Directors’ Committee was listed as the “principle strategic planning committee of the Institute” and the “decision-making body on all matters of a nature which concern the collaborative processes and activities of the Institute” (JBI 1998, p. 23). In addition, the Centre Directors’ Committee had the right to advise the Director on all matters relating to the administration of the Institute.

2002 saw a significant discursive disruption with regard to leadership and the way in which the Institute was differentiated from Centres. Historically, the Institute had taken on responsibility for ‘servicing’ membership in South Australia, acting as both the ‘lead’ and ‘state’ centre. In 2002, the Centre for Evidence-based Nursing South Australia (CENSA) was established as a separate entity with its own Director and Staff.

By 2003 an even clearer distinction was being made between the Institute and Centres with the strategic plan being revised to “clearly distinguish components specific to JBI from those affecting the Collaboration” (JBI 2003, p. 5). There was also discussion at this time about the difference between the Committee of Directors and the Committee of Directors’.
Management. The role of the Committee of Directors was defined as being responsible for decisions regarding the agreed processes relevant to the collaboration. However, the role of the Committee of Management was defined as being responsible for decisions regarding the agreed processes of the business operations of the Joanna Briggs Institute. Thus the discursive separation of responsibility was clearly set out, enacted and taken up.

At this time, the minutes of the Committee of Directors meeting reflect the need to further define the remit of the Committee of Directors and the objectives are stated as being to:

- Foster the aims of the JBI Collaboration
- Foster collaboration between the Institute and Centres
- Consider and adopt common approaches to the comprehensive systematic review of evidence and the generation, translation and utilisation of knowledge in clinical practice
- Develop relevant collaborative research programs across the collaboration.

During this time an Australian Centre Director questioned the benefit of belonging to the Joanna Briggs Collaboration. As the Collaboration started to grow (both with Centres and other types of groups), much of the discourse related to the potential for competition for funding (both from the Institute and from broader government bodies in their regions). This discursive statement resulted in the creation and dissemination of a series of further statements. The minutes from the Directors meeting reflect that the Memorandum of Understanding between the Institute and Centres states that the “relationship between the parties is that of independent contractors and not partners, joint venturers or principal and agent”.


At around the same time the Institute’s Committee of Management discussed the nature of the relationship between the Institute ‘proper’ and its Collaborating Centres with the following statement included in the 2004 meeting minutes:

“That JBI is recognised as an institution that actively supports its collaborating member institutions, however that the JBI structure is seen as too hierarchical. An emphasis towards the independence/ contributions of each Collaborating Centre would be of benefit to JBI’s image. It was also noted that JBI is unique in distributing revenue to Collaborating Centres and that in this regard a degree of hierarchy and accountability is warranted.”

Additionally, the relationship between the Institute and Centres was further clarified in the minutes which state that the Institute was not a funding body; that Collaborating Centres were independent bodies that voluntarily request to join the Collaboration and sign a Memorandum of Understanding to access benefits as detailed in the Operational Guidelines; that the Institute does not charge a levy or fee to participate and that Centres are recognised as Centres of the Institute which is perceived as a benefit because it is internationally recognised; that the relationship enables access to the expertise of other Centres and a mechanism for publication, quality control and peer review; and finally that Centres were able to run Institute designed workshops using Institute designed materials and keep profits.

By 2004 a significant discursive change occurred with the Joanna Briggs Collaboration being referred to as the “major international program of the Joanna Briggs” (JBI 2004b, p. 1). This discursive positioning of the Collaboration had important implications for how the relationship between the two groups was perceived and how they would now work
together. Within the organisational literature there was now a distinct move from the Institute being positioned as the ‘lead centre’ to being a separate and authoritarian identity.

Tensions over leadership of the Collaboration have been a consistent, although often with a subtle undertone, throughout the organisational discourse. Within the discourse surrounding the balance of power governance was particularly important and came to the fore in 2004. A discussion paper was presented by the JBI Executive at a Committee of Directors meeting in 2004 exploring the impact of expansion and development of the Joanna Briggs Collaboration and presented options for consideration by the Committee proposing decentralisation of governance of the Collaboration (JBI 2004b).

The Committee of Directors was presented with three options for consideration. The first saw the Committee of Directors as an intermediate decision-making body of the Joanna Briggs Institute, the second option proposed regionalisation of the Collaboration and the third option proposed a series of Collaboration specialty groups be formed.

This paper sought to generate discussion on ways in which the Joanna Briggs Collaboration could strengthen collaborative processes in ways that would enhance Centres abilities to both meet the obligations of the JBI MOU and the potential of Centres themselves. It stated:
“Although this global alliance will probably still be formally associated with JBI through the signing of an MOU and JBI will continue to deliver services to an increased number of members, the need for the Joanna Briggs Collaboration to form meaningful and productive relationships between Centres was seen to be of increasing importance, as was the creation of operational processes that assist Centres to pool resources to achieve their mission in their own geographical, professional or specialty sphere.” (JBI 2004b, p. 2)

Interestingly, the Committee were unanimous in recommending that no changes should be made at that time “as each Centre valued highly the internationalisation of the Collaboration”.

Instead, four regional groups were established as Standing Committees to develop and pursue strategies to increase regional communication and collaboration between centres. The regions were broken into Europe, North America, South East Asia and Australasia and the Pacific.

In 2008 The Collaboration Handbook was reintroduced and finally became the Joanna Briggs Institute Handbook. This handbook represented a set of agreed upon rules and regulations by which the collaboration would agree to adhere to. Although there was a process of agreement, the initial rules were set out by the Institute in the first instance as follows:
“This handbook has been specifically collated in order to provide those interested in the activities of the Joanna Briggs Institute (whether they are prospective members or collaborators) with a guide to the organisation, its structure, policies and operations. This document has been created to provide a footprint of organisational knowledge regarding general information, policy and process for the Joanna Briggs Institute, its staff, Collaborating Centres and other affiliated groups. The information contained in the handbook is designed to ensure clarity and transparency regarding Institute operations. It consolidates information previously housed in a variety of other organisational documents in order to provide a comprehensive framework and guidelines for action and decision-making across the Institute and associated groups.” (JBI 2008, p. 5)

The discursive constructions around ‘identities’ within the Collaboration and development of an understanding of the power relations between those involved are interesting. Of particular interest is the relationship between the Institute and groups in developing countries. Traditional views on power would place the groups in this region as powerless. However, a Foucauldian discursive view reveals that power can be exercised by creating meaning for social objects and that certain identities are able to have an influence – even groups that lack what might be termed as ‘traditional’ power. Groups in these regions were able to secure a voice as the only legitimate groups able to undertake meaningful and appropriate work for these countries and necessitate support from those centres and groups in the developed world. The discursive positioning of the Institute as a collaborator with the developing world is important. As demonstrated in the extant literature, there are significant power dynamics associated with collaborative activities between developed and developing countries.
Oneness and manyness: discursive construction of a collective identity

Freud (1921) wrote in *Group Psychology and the Analysis of the Ego*, that “in any collection of people the tendency to form a psychological group may very easily come to the fore” (p. 40). He observed that identification of a single common trait and the acknowledgement of the possession of a common substance could help this group formation.

Collective identity addresses the ‘we-ness’ of a group, stressing the similarities around which a group unite. Similarly Hardy, Lawrence and Grant (2005) suggest there is a strong relationship between collective identity and collaboration. They assert that, for the most part, effective collaboration is driven by the relationships between the participating members, which are negotiated on an ongoing basis throughout the collaborative process. Although collective identity alone is not sufficient to guarantee collaboration, it is an important and necessary first step in generating motivation to move forward.

> “Consequently, collaboration represents a complex set of ongoing communicative processes among individuals who act as members of both the collaboration and of the separate organizational hierarchies to which they are accountable.” (Hardy, Lawrence & Grant 2005, p. 59)

There were several important meta-dialogues that were critical to organising collective identity beyond the Institute in Adelaide. These revolved around the establishment of a shared challenge, shared language, strategies for communication and personal relationships. They, in turn, affected levels of engagement of individuals and groups with the ideologies of the Collaboration and explicitly connected local actions and activities within a broader context.
The Institute had to find a balance between 'oneness' and 'manyness' in the organisational discourse. It was important for members of the Collaboration to have a centralised, standardised vision and approach but it had to be able to be ‘adapted’ where necessary for different markets and contexts. Thus, the development of discursive statements around a shared goal and language as well as strategies for effective communication and relationship building were key in the organisational discourse.

**Shared challenge**

Tarnow (1997) writes of vision and mission statements as functioning as a “Unifying Action Declaration (UAD)” (p. 185). These short statements are constructed to (1) suggest an action, (2) identify this action only vaguely and (3) include a social categorisation (or collective identity).

Within the context of the Joanna Briggs Collaboration, this vision and mission statement has evolved as the members of the collaboration have diversified, thus enabling the group to remain cohesive. The discourse around this has been reproduced and transformed to be as inclusive and broad as possible and encompass a diverse range of disciplines and cultures.

Initially, this collective identity was characterised by a connection with a common goal: the desire to create an evidence base for nursing. This was discursively enacted through various channels, including the name of the Institute (at first the Joanna Briggs Institute for Evidence Based Nursing) and through other organisational texts such as the Annual Report through vision and mission statements. In 1997, the Institute’s vision was to be “the leading centre for Evidence Based Nursing Practice and Midwifery in Australasia, South East Asia and the Pacific Region” (JBI 1997, p. 7). By 2010 the vision is stated as
being “Evidence based practice as a central characteristic of all health services” with a separate mission stated as “To be the leader in producing, disseminating and providing a framework for use of qualitative and quantitative evidence to inform clinical decision making to improve health outcomes globally (JBI 2009, p. 8).

The connection between nursing and evidence provided participants (and potential participants) to identify with that issue as relevant and meaningful to their context and perceive themselves as being affected by it and able to contribute to it. As the desire to collaborate more widely evolved, so too did the discursive statements regarding the name of the Institute and its vision and mission. Finally, in order to be as inclusive as possible the name was shortened to simply the Joanna Briggs Institute, with a vision and mission statement that, as mentioned previously, was much broader both in terms of geography and discipline.

**Shared language**

The development of a coherent set of understandings regarding the challenge (as set out above), the process for addressing it and the nature of potential solutions can be established through the establishment of a shared language. Participants in the collaboration do not need to speak the same language per se but it is important that they understand something of the other languages used by other representatives and recognise various symbolic representations used by other partners and accept the validity of other interpretations.

Within the context of the Joanna Briggs Collaboration the language of evidence-based health care provides a useful example. The evolution of this discourse within the collaboration and the influence of an international ‘language’ around the terms used are
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interesting. Initially, the terms evidence ‘translation’, ‘transfer’ and ‘utilisation’ were used to describe collaboration activities. The term translation was changed to synthesis when the American Centres joined the Collaboration because to them translation related to linguistic translation rather than evidence review.

The discourse of the Collaboration and the evolution of a shared common language has also contributed to this sense of collective identity. Initiated around the language of nursing and research, it has evolved to include other health disciplines and also the language of business (i.e. with regard to strategic planning and administrative processes).

Hardy, Lawrence and Phillips (2006) highlight that participants in collaborative endeavours do not need to speak exactly the same language but to have an understanding of the other languages used by other representatives within the collaboration. They need to be able to recognise and identify with various symbolic representations used by other partners and accept the validity of other interpretations.

Participants in the Joanna Briggs Collaboration had varying degrees of knowledge and expertise around evidence-based health care. While they shared the common ‘language’ of health (in particular nursing) and research, the language of evidence-based health care was still evolving – this can be noted even just in the evolution of the discourse around evidence-based nursing, evidence-based practice and eventually the move to referring to evidence-based health care.

Interestingly, there has also been a very distinctive development in terms of a JBI specific language, which started as a body of acronyms, but has developed into quite a significant discourse, particularly in relation to collective identity. Coherence would play an important role in the development of a shared, common language, particularly in the early days of the
collaboration and again when the collaboration started to include participants from countries with English as a second language.

The number of acronyms used to ‘name’ various Institute developed resources (SUMARI, CReMS, QARI, NOTARI, RAPid, PACES, POOL, COOL and so on) made the language of the Institute exclusive rather than inclusive. This worked not only against communication with Collaborating Centres, but also with members. There was no longer a seamless common language and assumptions around participant understandings were taken for granted. This meant that communication between collaborating partners became uneasy.

In such a way collective identity had a more extensive reach than simply with Centres and those who currently collaborated with the Institute, and the language was starting to prove restrictive. It soon became clear that the introduction of ‘new’ terminology was going to have to happen over time and that more familiar language would need to be utilised in the meantime in order to create a more meaningful and inclusive relationship with both collaborators and members.

An important marker of the maturity of the Institute was the development of the JBI Model for Evidence Based Health Care. The conceptual model, first published in 2005, attempted to “situate healthcare evidence and its role and use within the complexity of practice settings globally” (Pearson, Wiechula, Court & Lockwood, 2005, p. 207). Interestingly, the discursive statements utilised within this model went on to become the framework utilised to formulate the Institute’s message strategy and thus its organisational discourse across most of its media.
What is also interesting here are the ‘disconnects’ that currently exists in the Institute’s organisational literature around terminology, which makes the development of a common, shared language challenging. For example, the JBI Model refers to Healthcare Evidence Generation, Evidence Synthesis, Evidence (knowledge) Transfer and Evidence Utilisation.

Health care Evidence Synthesis, in the JBI Model, refers to “the evaluation or analysis of research evidence and opinion on a specific topic to aid in decision-making in health care” (in essence, the conduct of systematic reviews), (Pearson, Wiechula, Court & Lockwood, 2005, p. 211). However, in the JBI Handbook section related to the Collaboration and the

**Figure 6: JBI Model of Evidence-Based Health Care**
types of Centres, it states that, “Collaborating Centres may focus on evidence review or linguistic translation or evidence transfer; or a combination of two or three of these foci” (JBI 2010, p. 39). In this instance, evidence review is used to refer to Collaborating Centres who undertake systematic reviews, rather than evidence synthesis.

A disconnect was also identified in the discourses across teams within the Institute. For example, the language utilised by the Education team and the Collaboration Support Unit differed at one point in time. This was significant, as the Education team was responsible for training staff in new centres and the support unit was responsible for overseeing and supporting the work of the Collaboration. The Education team were conducting training with groups around the world at the end of which trainees would have a completed protocol for a systematic review, which they would submit to the Collaboration Support Unit. Unfortunately the Collaboration Support Unit would not approve the protocols because they would consistently have problems regarding their methods (Court 2010, pers. comm. March 2). This disconnect in messaging would cause considerable confusion with regard to how the scientific work of the collaboration should be undertaken.

In order for international collaboration to be successful the Institute needs to provide consistent messaging, both internal and external, so that all parties can engage with the process and effectively undertake the work they need to do. In this sense, the organisational discourse is vitally important to achieving collective identity.

*Complete conversations*

Collaboration is often enacted in a series of conversations between people, representing a variety of organisations, around a particular issue. According to Hardy, Lawrence and Phillips (2006) if the conversations between these people break down then so does any
attempt at collaboration. They believe that, although action is the goal of collaboration, continued conversation is necessary if collaborative action is to ensue.

In order for the Joanna Briggs Institute to maximise the potential for collaboration, an annual face-to-face meeting of Directors of Collaborating Centres was established from the outset by the Executive Director to address the ongoing strategic development of the collaboration. This contributed to the ongoing development of a generalised sense of common membership and belonging to a broad community of concern around the issue of evidence-based health care.

Face-to-face relationships invariably involve power and dependency. The impact of culture in these meetings, particularly as the group became more diverse, was an important factor with regard to communication and the collaborative process.

It is important to consider the impact of ‘group think’ at this point (particularly throughout the early days of the Collaboration) versus the legacy of ‘differences’ (which came as the group grew) and how these contributed to the Collaboration, its output and functionality. Although a common language had been established where interpretive frameworks, symbols and assumptions were, for the most part, acknowledged as the collaboration grew so too did the differences between collaborating parties and their needs and understandings.

While this diversity had great potential to contribute to creativity and innovation within the collaboration, it would also be a challenge to manage the different ‘voices’ of the collaboration and ensure that all were equally heard. Dominant voices, or voices that were perceived to speak ‘on behalf of the group’, were clearly evident, particularly in the early days of the collaboration. These were often ‘Western’ voices and they contributed to
determining the direction of the Collaboration, the generation of ideas, methodology and leadership.

It is also important, however, to note here the ‘silent’ voices, those that are absent from the discourse such as those from countries with English as a second language (including but not limited to Asia and Africa). It was not until much later that these voices started to be heard.

The conversations of the Collaboration had to take place within the context of the work of the Collaboration. The discursive constructions that legitimate the activity of the group, the forms of knowledge production, frames of reference, ways of understanding what the Collaboration is trying to achieve and how it sets about achieving it were first introduced in draft ‘working rules and conditions’ for Collaborating Centres of the Joanna Briggs Institute for Evidence Based Nursing and Midwifery in 1998. These draft regulations provided a framework for discussion and conversations around how the collaboration would function and what potential future directions it may take. The fact that these working rules or regulations are agreed upon by the Collaboration at the face-to-face meeting every year means that all of the individuals involved have an opportunity to debate and agree on the content.

The introduction of social media as a means of communication across the collaboration is an interesting element of the discourse. This communication transition to the use of Skype, Facebook and Twitter has brought new dynamics and issues of connectivity to the collaboration. The complex machinery and art of conversation, and the exchange of thoughts and ideas has taken a new direction. Of course, the limited uptake of these new tools may be reflective of geographical location and the ability to connect to the internet,
but it may also be linked with generational differences and preferences for communication style.

Committee of Directors’ meetings are run by the Chair (the executive Director of the Institute) and during these meetings every member of the Committee is given an opportunity to speak. This enables the ‘quieter’ voices to be heard. It does not always mean that they utilise this opportunity and there will be valid reasons (e.g. cultural) why they don’t. Equally, the institution of social ‘events’ that are run in conjunction with face-to-face meetings of the Collaboration Directors are aimed at facilitating social discourses to enhance communication and collaborative process. These events provide opportunity for group members to interact with each other in different ways and have been a strategic and deliberate attempt to facilitate interaction across the groups of the collaboration.

Collaborating Centres also provide activity reports to the Institute and a clear disruption to this discourse occurred in 2010 when the focus of these reports changed from negative (focus on what Centres do not achieve) to positive (focus on Centre achievements). This is an important development in the communication between the Institute and Centres as previously there had been no opportunity to celebrate achievement – the focus was on what Centres had not achieved. This positive dialogue created a more constructive and encouraging environment in which collaboration could take place.

**Personal relationships**

“Sparking interest in collaboration is tied to emotion” (Collins cited in Hardy, Lawrence & Phillips 2006; Westley cited in Hardy, Lawrence & Phillips 2006, p. 103). Personal relationships have played a significant role in the growth of the Joanna Briggs Collaboration. As the Joanna Briggs Institute history book states, “In order to establish
such a collaborative approach, Alan Pearson used valuable contacts built up during his time in Australia" (Jordan, Donnelly & Pitman 2006, p. 17). Many of the initial Centre Directors had an established relationship with the Institute’s Executive Director, either as a PhD supervisor or in a previous professional capacity.

These personal relationships influenced and shaped the discourse of the collaboration for a significant proportion of the first decade of the Institute’s existence. Not until recently did Collaborating Centres join because they were aware of the Institute as an international entity, rather than because of a relationship or connection with the Executive Director.

In the first year of operation the Directors of all five Collaborating Centres had a personal history with the Executive Director, either as past students or colleagues. Today, most of the new Collaborating Centres join having met the Executive Director or another member of staff at a conference or simply through reference and reputation of the Institute itself. It is anticipated that these relationships are different to those who joined through a personal relationship and that they potentially engage with, understand and contribute to the work of the Institute and the Collaboration differently. This distinction could also be made due to the organic and evolutionary nature of the internal discourse of the Institute and the fact that older Centres have a sense of the history of this dialogue and thus relate to the Institute in a different way to what, perhaps, a newer Centre might. The table below outlines the various ways in which Centre Directors were connected to the Executive Director of the Institute, Professor Alan Pearson, at the time they joined the Collaboration. It is interesting to note that many of the early Centre Directors had a previous professional relationship with the Executive Director. Later, many were past students and more recently Directors had no prior connection.
### Table 4: Centre Director connections to the Institute Executive Director

<table>
<thead>
<tr>
<th>Director</th>
<th>Centre Country</th>
<th>Years</th>
<th>Connection to ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Davina Allen</td>
<td>Wales</td>
<td>2005 - 2007</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Emily Ang</td>
<td>Singapore</td>
<td>2009 - present</td>
<td>Student</td>
</tr>
<tr>
<td>Dr Paul Bennett</td>
<td>Wales</td>
<td>2007 - 2010</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Debra Bick</td>
<td>UK</td>
<td>2006 - 2008</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Petra Brysiewicz</td>
<td>South Africa</td>
<td>2008 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>AProf Tracey Bucknall</td>
<td>Australia</td>
<td>2003 – 2004</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Sandra Capra</td>
<td>Australia</td>
<td>2003 - 2007</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Anne Chang</td>
<td>Hong Kong/Australia</td>
<td>1996 – present</td>
<td>Fellow student</td>
</tr>
<tr>
<td>Prof Yann-Fen C Chao</td>
<td>Taiwan</td>
<td>2005 - 2007</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Ratanawadee Chontawan</td>
<td>Thailand</td>
<td>2002 - 2006</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Clare Collins</td>
<td>Australia</td>
<td>2007 - 2008</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Grace Croft</td>
<td>Australia</td>
<td>1996 - 2002</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dina da Cruz</td>
<td>Brazil</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Janine Dizon</td>
<td>Philippines</td>
<td>2010 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Sylvia Florescu</td>
<td>Romania</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Anthony Forrester</td>
<td>USA</td>
<td>2004 – 2005</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Karen Francis</td>
<td>Australia</td>
<td>2010 - present</td>
<td>Student</td>
</tr>
<tr>
<td>Prof Heather Gibb</td>
<td>Australia</td>
<td>2007 - present</td>
<td>Research assistant</td>
</tr>
<tr>
<td>Prof Rhonda Griffiths AM</td>
<td>Australia</td>
<td>2001 – present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Prof Karen Grimmer</td>
<td>Australia</td>
<td>2003 - 2008</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Margaret B Harrison</td>
<td>Canada</td>
<td>2004 – present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Prof Desley Hegney</td>
<td>Australia/Singapore</td>
<td>2004 – present</td>
<td>Student</td>
</tr>
<tr>
<td>AProf Jia Hongli</td>
<td>Fudan</td>
<td>2004 – present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Heng Bee Hoon</td>
<td>Singapore</td>
<td>2008 - present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Lisa Hopp</td>
<td>USA</td>
<td>2004 – present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Veronica James</td>
<td>UK</td>
<td>2003 - present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Name</td>
<td>Nationality</td>
<td>Years</td>
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</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Susan Jones</td>
<td>USA</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Carole A Kenner</td>
<td>USA</td>
<td>2004 - 2009</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Bridie Kent</td>
<td>NZ/Australia</td>
<td>2002 – present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Alison Kitson</td>
<td>Australia</td>
<td>2009 - present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Susan Koch</td>
<td>Australia</td>
<td>2003 – 2004</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Ling-Ling Lee</td>
<td>Taiwan</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Judy Lumby</td>
<td>Australia</td>
<td>2007 - 2008</td>
<td>Student</td>
</tr>
<tr>
<td>Susan Mace-Weeks</td>
<td>USA</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Irena Madjar</td>
<td>Australia</td>
<td>1996 - 1998</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Prof Mary Magennis</td>
<td>Australia</td>
<td>1996 - 1998</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>AProf Judy March</td>
<td>Australia</td>
<td>2006 - 2008</td>
<td>No connection</td>
</tr>
<tr>
<td>Mr John McArthur</td>
<td>New Zealand</td>
<td>1996 - 2000</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Patricia McInerney</td>
<td>South Africa</td>
<td>2004 – present</td>
<td>No connection</td>
</tr>
<tr>
<td>Teresa Moreno-Casbas</td>
<td>Spain</td>
<td>2004 – present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Pei Fan Mu</td>
<td>Taiwan</td>
<td>2007 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Leah Mwai</td>
<td>Kenya</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Rhonda Nay</td>
<td>Australia</td>
<td>2002 – 2003</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Eui-Guem Oh</td>
<td>Korea</td>
<td>2007 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>AProf Debra Parker</td>
<td>Australia</td>
<td>2008 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Judith Parker</td>
<td>Australia</td>
<td>1996 - 2003</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Carol Pellowe</td>
<td>UK</td>
<td>2008 - 2010</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>AProf Wilawan Picheansathian</td>
<td>Thailand</td>
<td>2008 - present</td>
<td>Student</td>
</tr>
<tr>
<td>Prof Kay Roberts</td>
<td>Australia</td>
<td>2001 – 2002</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Susan Salmond</td>
<td>USA</td>
<td>2005 – present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Morankar Sudhakar</td>
<td>Ethiopia</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Dr Kwat Kwat Swe</td>
<td>Myanmar</td>
<td>2006 – present</td>
<td>Student</td>
</tr>
<tr>
<td>Asahngwa Constantine Tanywe</td>
<td>Cameroon</td>
<td>2009 - present</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof David Thompson</td>
<td>Hong Kong</td>
<td>2002 - 2008</td>
<td>Professional colleague</td>
</tr>
<tr>
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<td>Country</td>
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<tr>
<td>Prof Alison Tierney</td>
<td>Australia</td>
<td>2002 – 2004</td>
<td>Professional colleague</td>
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<tr>
<td>Prof Debbie Tolson</td>
<td>UK</td>
<td>2009 - present</td>
<td>No connection</td>
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<tr>
<td>Catherine Tracey</td>
<td>New Zealand</td>
<td>2000 – 2002</td>
<td>No connection</td>
</tr>
<tr>
<td>Prof Jennifer Watson</td>
<td>Australia</td>
<td>1998 - 2001</td>
<td>Student</td>
</tr>
<tr>
<td>Prof Robin Watts</td>
<td>Australia</td>
<td>1996 - present</td>
<td>Professional colleague</td>
</tr>
<tr>
<td>Dr Sylvia Wilcock</td>
<td>Scotland</td>
<td>2004 - present</td>
<td>No connection</td>
</tr>
</tbody>
</table>

Although not noted in the table, it is also important to appreciate that many of the Directors listed were ‘second’ Directors (i.e. not the original Director of the Centre) and thus did not necessarily have a prior connection to the Executive Director.

**DISCUSSION**

Understanding collaboration discursively enables an examination of the collaborative process and how individuals navigate and negotiate issues to be addressed by the collaboration as a whole and by their groups individually. In this phase discourses were treated as strategic resources composed of complex linkages that could systematically be broken down into a set of meaningful circuits with which participants engage in order to collaborate internationally. The power of discourse in these circumstances lies in its ability to utilise specific discursive statements to shift rhetoric to practice.

In the case of the Joanna Briggs Institute and its relationship with Collaborating Centres and the broader evidence-based community, specific discursive acts and consequential practices altered the position of the Institute and its ability to collaborate with various bodies on the international stage. It was possible to alter the organisation and its
environment, creating a legitimate ‘voice’ for the Institute using discursive statements and symbols.

Two discursive circuits of connectivity were identified in this phase of the study. The first circuit positions the Joanna Briggs Institute as a global leader in the evidence-based health care movement and as an international and multidisciplinary organisation. This circuit can be thought of as comprising external discourses that enable international collaboration. The second circuit of connectivity positions the Joanna Briggs Institute as a leader within the Collaboration and as a member of a collective with the common goal of creating an evidence base for nursing, midwifery and the allied health professions. This circuit can be thought of as comprising internal discourses that enable international collaboration.

Although much of this discursive activity occurred concurrently, it is reasonable to assert that the external dialogue around global leadership within the evidence-based health care movement and international and multidisciplinary profiling had to occur first in order to establish the organisation’s appeal to other groups as a potential collaborator. Once this ‘buy in’ was established, it was then possible to navigate the sometimes murky and turbulent waters of the collaborative process and to determine the internal dynamics and relationships of the Collaboration as a whole.
This circuit of connectivity is situated within the broader discourse identified as globalisation. Specifically, it relates to the ways in which organisations must position themselves or construct internal and external dialogues to effectively facilitate relationships across the global community. Importantly, the organisational discourses identified here relate to other ‘globalisation’ discourses such as development, deregulation and new world orders. Following Foucault, the discursive strategies employed here may be seen as a strategy of power.
The construction of discourses within the annual reports and other external organisational documents provided a powerful distillation of the relationship between the Institute, the Collaborating Centres and other external groups, the ways in which they relate to and communicate with one another to establish and clarify ways of working together.

**Figure 8:** Internal circuit of connectivity: Discursive positioning of the Joanna Briggs Institute as a leader of the Joanna Briggs Collaboration and a member of the collective group

The organisational discourse in this section revealed a grand narrative of Collaborating Centres as having a role to play in the broader machinery of the Joanna Briggs Institute. Collaborating Centres are discursively positioned as having an explicit responsibility to deliver results imposed from a ‘higher level’ (i.e. the Institute in Adelaide, Australia). While at the start they were constructed as almost equal ‘partners’, over time the progressive
narrative alters this equilibrium to the point where a clear authority exists and Centres are considered one of several ‘programs’ of the Institute.

Equally the power distribution is further compounded, as while Centres are integral to the business of JBI, they also require the infrastructure of JBI to be successful in their activities by way of financial and methodological support and leadership. The discursive power tensions of ‘powerful’ and ‘powerless’ within the organisational literature and the discourse of dependency was not always explicit but subtle statements were identified that implied this sort of relationship existed. The discourses identified within this circuit of activity emphasised the schism between Centres as being subordinate to the JBI and JBI as being superior and it seems to be the eventual acknowledgement of these relationships that makes international collaboration successful in this case.

CONCLUSION

It is challenging to do justice to the discursive activity of such a complex and diverse collaboration. This chapter endeavoured to demonstrate how one organisation strategically developed new (and intervened in existing) discourses to facilitate opportunities for international collaboration. It is clear from this analysis that there are significant external as well as internal discursive dynamics that contribute to the success of collaborative endeavours that occur across the global community. It is also clear that discourse may be manipulated and controlled in order to enable collaboration and to influence the ways in which collaboration takes place. Organisational discourses have been identified here as being movable, changeable and malleable devices that may be utilised in a strategic way to achieve particular goals. It therefore seems that it may be
possible to, on this basis, create a model for international collaboration that employs discourse in this way to guide future attempts in this area.
Discussion

Discourse in Context: the case for international collaboration

"Always design a thing by considering it in its next larger context - a chair in a room, a room in a house, a house in an environment, an environment in a city plan."

-- Eliel Saarinen (cited in Cramer & Yankopolus 2005, p. 555)

SYNOPSIS

A significant amount has been published regarding international collaboration. Discourses on the topic are considerably varied with many flaunting it as an all-inclusive solution to global health needs and others dismissing it as another failed attempt to mask the enormous divides between those who have and those who have not in the global community. In reality it is an imperfect science that involves many unpredictable variables, not least of which are the diverse complexities of human interaction and communication. It is therefore important that theories and approaches to international collaboration are firmly placed within pragmatic frameworks. Having examined the international discourse around international collaboration in health research and conducted a discursive case analysis of the same, it is now timely to integrate the results of those phases in an attempt to resolve some of the much debated issues and offer a new model for international collaboration.
INTRODUCTION

Discourses interact with and are mediated by other discourses to produce new, different, and forceful ways of presenting an issue (Carabine cited in Wetherell, Taylor & Yates 2001). In this study of international collaboration, discourse contributes to the way in which we understand, experience and respond to various perspectives on and approaches to collaborative efforts across international borders. As Fairclough and Wodack (cited in Grant & Hardy 2004) note:

“Discourse is not produced without context and cannot be understood without taking context into consideration... Discourses are always connected to other discourses which were produced earlier, as well as those which are produced synchronically and subsequently.” (p. 7)

Inter-textual (or integrative) discourse analysis, therefore attempts to link particular discourses, their meanings, construction and effects, to the context in which they arise. In the case of this study, the discourses located in the extant literature are taken to be reflective of international perceptions of the reasons to collaborate and strategies to do so effectively. These discursive perspectives then provided a lens through which to view a discursive case analysis of international collaboration. The discursively constructed relationships between countries and regions on the international stage impact the way in which they communicate to and about each other in the collaborative process.
EXTANT LITERATURE: THE MODERN AND THE COLONIAL

The discourses around international collaboration within the extant literature fell broadly into two frameworks, that of modernisation and colonialism. The function of these discourses was to create a space within which certain activities could be described and facilitated that enable collaboration. However, each framework, or lens, provided interesting insight into the motives behind the collaboration and the strategies utilised to achieve the end goal.

The development of these discourses, as articulated in the extant literature, has occurred over several decades. International collaboration as a discourse within the health sciences specifically has been prominent in the literature for at least the last forty years. It would seem that the broad organising premise behind this development was the belief that the conduct of health research across international borders would strengthen capacity and increase opportunities to find answers to universal health questions. However, the relationships between those who sought to collaborate were often unequal and thus the strategies utilised to facilitate collaboration involved the articulation of significant knowledge and power constructs.

In this sense, the discourses reveal interesting perspectives regarding notions of truth, power and knowledge, with particular reference to the North, or developed societies and the South, or developing countries. Within this, concepts of power and knowledge relating to individual organisations and organising are also addressed.

The examination of the discourses through a colonial lens provided an opportunity to view how international collaboration was perceived as the advancement of health research, researchers and health outcomes in poor countries as being reliant on those in the...
developed world taking an active role in promoting and orchestrating a better circumstance that was in line with developed country initiatives and priorities.

International collaboration, through this lens, meant the investment of developed countries finance, technology, resources and expertise to overcome the general underdevelopment and inability of developing countries to improve. Researchers in developing countries are viewed here as incapable, even backward, and in need of guidance from more equipped researchers from developed countries to impart their knowledge, understanding and skills.

Referring back to Foucault and his conceptualisation of governmentality as including a range of controlling techniques applied to a wide variety of objects (i.e. from control of the self to control over others) and providing a new understanding of power and knowledge. Power, in this sense, can manifest itself in such a way as to produce knowledge and discourses that may influence or guide the behaviour of others.

Fanon (cited in Schech & Haggis 2002) writes, “Colonial domination manages to disrupt in spectacular fashion the cultural life of a conquered people ... [T]he intellectual throws himself in frenzied fashion into the frantic acquisition of the culture of the occupying power and takes every opportunity of unfavourably criticizing his own national culture” (p. 103). In this sense, those 'being occupied' buy into the idea of needing the help of those external to their own culture; of their own knowledge and approaches as being incorrect or invaluable (the colonised consciousness). In the extant literature, it was these individuals who would tend to leave their own country and go to work in the country who had colonised them (i.e. brain drain).

Conversely, the modernisation lens gave rise to perspectives that recognised cultural distinctiveness and traditional values and approaches from one country to another. This perspective did not exclude the voices and contributions of researchers in developing
countries, but rather found connections with them and utilised these to strengthen international research programs.

The dynamics of these relationships were quite different to those presented through the colonial lens as they consider all views and values as legitimate. The complex interplay between each individual or group involved in the collaborative process is driven by a mutual desire to reach a common end point that is derived from a common goal.

What is most interesting about both “versions” of the international collaboration discourse is the positioning of relationships between developed and developing countries. For the most part, this distinction was derived from the development discourse. As Escobar (cited in Schech & Haggis 2002) states:

“After four decades of this [development] discourse, most forms of understanding and representing the Third World are still dictated by the same basic tenets. The firms of power that have appeared act not so much by representation but by normalisation; not by ignorance but by controlled knowledge; not by humanitarian concern but by the bureaucratization of social action. As the conditions that gave rise to development become more pressing, it could increase its hold, refine its methods, and extend its reach even further.” (p. 89)

The development discourse, particularly, places knowledge and power firmly in the hands of developed countries. This is not because those in developing countries are unable or unwilling. Researchers and scientists in these regions possess knowledge, but it is repressed and controlled by other more powerful influencing factors.
Both of the broader discourses are developed around the construction of two distinctive groups (i.e. developed and developing) where one is defined as having an advantage or privilege over the other (be that advantage economic or knowledge related). Within each discourse, however, these relationships are valued differently. The colonial lens discursively places those in developing countries as being one homogenised and inferior group so that, regardless of the complexities of the context, those in poorer countries require richer countries to reform and educate them regarding the conduct of research. The modernisation lens, however, discursively places those in developing countries as being unique and in possession of valuable knowledge that can contribute to ongoing scientific investigation and the improvement of health outcomes. It does not exercise power over another group, but rather determines what each group can contribute to the mutual endeavour of knowledge development.

Across the board, the relationships between ‘advantaged’ and ‘disadvantaged’, ‘developed’ and ‘developing’, ‘North’ and ‘South’ and so on were held up to be altruistic endeavours, but in fact the reality was often quite the opposite. The paradox is that, while statements and claims of altruism exist, most if not all, collaborators (regardless of location) set out to collaborate to meet their own ends, not those of others. It would seem that the challenge for those seeking to collaborate internationally is to recognise this and identify mutually beneficial opportunities for collaboration.

**ORGANISATION SPECIFIC DISCOURSES: INTERNAL AND EXTERNAL**

The organisation specific discourses identified in the second phase of the analysis were concerned with internal and external dialogue. This dialogue was utilised strategically to position the Joanna Briggs Institute on the international stage as a desirable group to
collaborate with, and to facilitate effective communications internally once collaborative relationships had been established.

Although trust and communications are critical to collaboration, Hardy, Lawrence and Phillips (2006) argue that power and conflict are equally important. They state that the examination of interorganisational collaboration (as in the case of the Joanna Briggs Collaboration) has often:

"dismissed power and conflict as having a purely negative effect: conflict is said to distort communication, while the exercise of power disrupts the trust-building process. But power and conflict are also potentially positive, creative elements that are central to the very process of organising. They signal that partners are equal players, each contributing to a joint definition of the problems and to common solutions." (p. 21)

To this way of thinking, power and conflict are essential ingredients for collaboration to be successful, especially when collaboration is being conducted on the international stage and attempts to engage a broad, multidisciplinary audience across different cultures and perspectives. It is also particularly important when dealing with groups from more and less privileged regions (i.e. it begins to account, at least to a small degree, for the differences between developing and developed countries).

For the Joanna Briggs Collaboration, the broad and wide-ranging discussion and debate over the lifespan of the organisation has shaped the way in which the Collaboration and collaborative strategies have evolved. The discourses located within the organisational literature reflect a myriad of changes and developments related to the ways in which the collaborating parties relate to and interact with one another. This includes the relationship
between the ‘Institute’ and ‘Centres’ as well as the relationship between individual ‘Centres’. Much of this was individually, personality-driven discourse that influenced and shaped the direction of the groups involved.

Power is not contingently situational but also historically formed and thus the discursive case analysis of the Joanna Briggs Institute provided some interesting insight into the relationships between different groups and how they have evolved. Power has, in fact, defined, constituted and shaped the collaborative process and given rise to a unique model that is at once hierarchical but also democratic in its approach. Ultimately what this means is that, although contributions from all groups are considered and valued, administrative authority is held (necessarily) by one central group.

INTEGRATIVE ANALYSIS: PUTTING HUMPTY TOGETHER AGAIN

Each of the first two phases sought to unpack and deconstruct previous and current discourses, both in the public domain and organisation specific, related to international collaboration. This phase seeks to re-assemble these discourses in a way that might inform future attempts at international collaboration in health research. Based on findings from the first two phases, this section seeks to articulate the complexities surrounding approaches to international collaboration and to propose a model for addressing such complexities in any attempt to undertake collaboration of this nature. The analysis aims to respond to the confluence of identities, cultures, objectives, and multiple, intersecting and competing objectives of organisations involved in the collaborative process.
It is therefore interesting to examine the organisational discourse of the Joanna Briggs Institute related to international collaboration through the dual lenses of modernisation and colonialism as identified in the first phase of this study.

From the Colonial ...

If we are to examine the Joanna Briggs Institute through the lens of colonialism, or academic colonialism in this case, we can see that it fits with Foucault’s formulation of discourse and power/knowledge as the superiority of developed countries over developing countries. The discourses within this framework identify developed countries as possessing knowledge and authoritative ways of knowing and view developing countries as inherently inferior and reliant on scientists and researchers of the developed world to be able to undertake high quality research.

Foucault’s notions of power/knowledge indicate the importance of the cultural in the structuring of dominance. Interestingly, this exertion of power and knowledge and the superiority of developed over developing, within this framework, becomes the means by which they know themselves. By this, I mean researchers in developing countries come to believe that the only way to conduct high quality research is to partner with researchers in the developed world to access their knowledge, resources and importantly funding.

The counter discourse of resistance to dominant power/knowledge structures is also evident within this framework.

The goals of the Collaboration are derived from a Western/developed country standpoint. They are steeped in First World theoretical and cultural perspectives with limited consideration for the historical nuances of the Third World or the challenges faced by those
in developing countries. These views are rationalised as the provision of ‘knowledge’ in order to ‘transform’ practice for the improvement of global health outcomes.

But can knowledge be managed and utilised in the same way to meet the same ends in developing countries as in the developed world – and is the desire really there? Knowledge, in this instance, is collected, codified and disseminated to professionals, carers and consumers in Western formats using Western ideologies and is not (currently) located within a developing country system or framework.

It could be argued that the Institute has ‘colonised’ thinking in developing countries (and perhaps even more broadly) in relation to evidence-based health care. It could be argued that the Institute has used its power, knowledge and influence to increase its own international profile, and compete with and usurp the power and influence of other similar organisations on the international stage.

Collaboration is as much about the people involved as it is about anything else. Thus, this ‘systematised’ approach to collaboration in which others are ‘used’ to achieve certain goals and outcomes in a mechanistic way is unlikely in this case. Collaboration takes place in conditions of uncertainty and flux and the people involved are dynamic and changing so the influences and contributions in this type of long-term collaboration are unpredictable to a certain degree with high levels of variability.

... to the Modern

Modernisation involves industrialisation, urbanisation, increasing levels of literacy, education, wealth and social mobilisation, and more complex and diversified occupational structures as well as the expansion of scientific knowledge through research.
The attitudes, knowledge and culture of people in a modern society differ greatly from those in a traditional society. As the first civilization to modernise, the West leads the acquisition of the culture of modernity. That said, the difference between modernisation and colonialism is that the lack of homogeneity between societies is acknowledged and respected. In this sense, modernisation does not mean Westernisation. Non-Western societies can modernise without abandoning their own cultures and adopting wholesale Western values, institutions and practices (as might occur within a colonial framework). Instead, modernisation strengthens those cultures and reduces the relative power of the West (Huntington cited in Schech and Haggis 2002).

In this instance, Foucault’s notions of power and knowledge are considered somewhat differently. There is inherently power and knowledge possessed by both developed and developing country researchers. According to Foucault (1980) “we should admit that power produces knowledge … That power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute … power relations” (p. 78).

Within the modernisation framework, the Joanna Briggs Institute can be viewed as fostering and resourcing research capacity in collaboration with developing countries. Examining the Institute through this lens provides some opportunity to gain insight into the dynamics between researchers in the developed and developing world.

Sustainable capacity building is achieved in this model through shared ownership and ongoing support that is essentially the same as that provided to other Centres across the world. Centres in developing countries are not provided with additional financial aid, although the Institute does support the development of proposals to funding agencies that are submitted by Centres in developing countries. They are also provided with assistance
Discussion

through support of the work they are bound to conduct through obligation via a Memorandum of Understanding.

In this case of international collaboration all participants are equally supported and have the right to discussion and debate and consensus is valued. While for the most part there is a horizontal alignment of organisations, rather than vertical or hierarchical relationships, which is the preferred approach in the literature, there is still a sense of one group having administrative ownership of the collaborative process (as well as scientific).

Working rules are developed by the central agency (i.e. the Institute), but these are agreed to annually by the Collaboration as a whole, thus providing a sense of transparency to expectations and guidelines for work. Each Centre and group is equated equally and with equal voice where issues of language, culture and tradition are accounted for and as far as possible there is an identified common language and identity that respects difference.

Collaboration involves interactions between people. It is the product of relationships, not something discrete or rule bound. This is not to suggest that there are not frameworks that would not be useful to guide these interactions, but there seems to be no specific ‘gold standard’ to follow to ensure success. The unpredictable behaviour of the individuals involved prohibits the implementation of strict rules to be adhered to. However, the generative nature of the relationship between groups in this collaboration is achieved through discursive strategies that enable and empower groups, providing a sense of ownership of the mission and vision of the broader group.
A NEW MODEL FOR INTERNATIONAL COLLABORATION

Collaboration, organisations and organising are fundamentally discursive activities. They are, in essence, discursive activities that focus on the facilitation of human relationships and communication. While entirely equal relationships in collaboration might be ideal (as is perhaps indicated within the modernisation perspective), it is not necessarily realistic and perhaps a combination of the two perspectives to inform the collaborative approach is required. This does not mean that an entirely hierarchical approach is appropriate either. What is suggested here is that the complex environment within which international collaboration takes place requires a ‘higher authority’ to administer the process to everyone’s benefit. The role of this higher authority is not to engineer the system or hold a monopoly on knowledge and power structures within the collaborative process. Rather, it would ideally perform the activities that the other participants have neither the capacity nor the desire to undertake.

There are, however, considerations that should be given thought to by the nominated higher authority throughout the collaborative process. For the most part, these considerations relate to discursive strategies and mechanisms that help to foster effective communication and facilitate strong collaborative relationships.

Contemporary approaches to collaboration within the field of healthcare need to be cognisant of the broader global context within which they exist. Such approaches should not enforce control or impose predefined rules. Rather a transparent and flexible approach to governance in which pre-existing systems, cultures and diversity are respected and, in fact, thrived upon. The creation of a collective identity is particularly important here, but needs to be balanced against the need for a coordinating body to administer the process.
As this study has demonstrated, much of the activity undertaken by organisations wishing to collaborate is done discursively. Collaboration is effected through the use of language and the generation of other various communicative activities that draw groups together, provide frameworks of understanding, identity and mutually agreed to goals and objectives. The following model provides a staged framework that accounts for the internal and external communicative strategy required to foster effective collaboration on the international stage. Central to this thesis are the influence and impact of the interpersonal relationships of those involved in the collaboration and the power constructs within which they communicate. It draws together the contemporary dynamics of international collaboration as identified in phase one and the specific organisational discursive structures as identified in phase two.

**Discursive model for international collaboration in health research**

The integrative analysis conducted here suggests that both internal and external discourses should be considered when positioning an organisation to effectively collaborate on the international stage. It also suggests that this should occur within a framework that values difference between groups, identifies mutual benefit and empowers collaborating partners with limited resource and capacity if it is to be successful, while balancing this against the necessity for an administering body that oversees the operational aspects of the collaborative process.
Invariably, discourse and communication is important to organisational functioning and development and, in turn, the potential for collaboration. The various elements within this model are designed to facilitate a process of discursive framing and relationship building which enable groups to find common ground and locate themselves in a pragmatic way that situates them as unique contributors to the collaborative process. As such, there are three key elements to this model for international collaboration, namely ‘Common Vision’, ‘Collective Identity’ and ‘Collaboration’ (the three Cs), which are outlined in more detail below.
Discussion

Common vision

The first discursive element relates to the establishment of a common vision or mission that is aligned with common ideologies of the groups seeking to participate in the collaboration. It should create a sense of unity across settings, cultures and collaborating parties. The use of language and symbolism and the attribution of meaning to things as a strategy for making sense of the world for different groups wishing to collaborate across international borders is vital. Traditional approaches to international collaboration frequently neglect the use of language and its importance in the creation of a common vision and mission that can bind groups and forge strong, constructive, productive relationships.

As demonstrated throughout this research, international collaborative efforts have often failed due to a lack of clarity between groups around the objectives of the collaboration. The discourse around the creation of a common vision and mission should reflect the direction in which all groups wish to move, and give shape and direction to the collaboration.

Once established, this common, centralised, standardised vision should be consistent across all organisational documents that relate to the collaboration and should be utilised to focus the activity and language of the collaboration across all work programs and projects. It should be possible for participants to internalise the vision and mission, and align them with their own points of reference (be those contextual, cultural, organisational or political).
Collective identity

The second discursive element relates to the establishment of a collective identity. In order to realise a common vision, there must be a common understanding of the sameness and uniqueness of the groups involved as a collective but also of their difference. The discursive strategies, linguistic turn and communicative processes utilised to achieve this must be ongoing and evolutionary. Particularly for long-term collaborative ventures where the groups involved may change.

The discourse related to this activity needs to be inclusive enough to account for cultural difference while enabling a sense of ‘team’ and cohesiveness. Utilising a modernisation lens this approach must be enabling and engaging, it must legitimise all participants and their capacity to contribute in a meaningful way. The discourse relating to collective identity must be context-driven and use narratives that facilitate common understandings.

Collaborative ‘social rituals’ that create a sense of connectedness, on more than simply a professional level, may be helpful in this endeavour. These rituals provide an opportunity for personalities to develop a more in depth understanding of each other’s national and/or cultural perspectives and gain insight into how each group functions in the world. This ‘socialisation’ to a broader entity (that goes beyond national borders, politics and culture) is a vital discursive element in the collaborative process.

Discursively constructed collective identity is particularly important, as it is believed to result in innovative and synergistic action that can be applied on a large scale to a potentially diverse collection of individuals and groups.
Collaboration

The final discursive element brings all elements together, connecting them to result in successful collaboration. The model is completed by a final circuit that represents the discursive construction of a pluralistic and democratic approach to international collaboration that is cognisant of the needs of all groups involved. Variety and multiplicity across collaborative efforts is complimented by and balanced against a certain level of homogeneity. It should be possible to embed the discursively constructed vision and collective identity within the broader organisational structures of the groups participating in the collaboration. It is therefore imperative that these are broad enough to be applicable across a wide variety of participants but specific enough to provide the necessary frameworks to result in driving tangible output.

Power is also an important aspect of this conceptualisation of international collaboration. This model aligns with Follet's (cited in Clegg, Courpasson & Phillips 2006) conceptualisation of power, where power is conceived of as ‘coactive’ rather than ‘coercive’. Follet was concerned with the democratisation of power, distinguishing ‘power with’ rather than ‘power over’. Foucault argued that contemporary forms of power were engaged in a struggle for the soul and Follet's view was that coercive power was the curse of the universe while coactive power could be used to enrich and advance every human soul. Her belief was that coactive power could be achieved through cooperative governance. In this sense, attempts to collaborate internationally where discursive strategies are utilised to create a sense of collective identity and ownership of a common vision have the potential to result in constructive, productive and effective collaborative relationships.
CONCLUSION

Collaboration in health research is a moving feast; it is not made up of consistent, stable, immutable relationships that are fixed in place. The context within which collaboration of this nature takes place is diverse and inimitable and will be different with each collaborative relationship forged, and thus it is challenging to set in place rules and conventions for effective collaboration on this scale. However, there are discursive strategies that may be utilised to achieve a more comprehensive and in-depth understanding of those involved and facilitate effective communication in order to work toward mutually beneficial outcomes.

With the concept of an international community on the rise and the resulting hybridity of culture and identification of global citizenship, increasing contemporary approaches to international collaboration should now move beyond traditional notions of power and knowledge to encompass a more dynamic, inclusive and pragmatic focus. Antiquated and complacent notions of developing and developed countries, and the associated conceptualisations around who can contribute and in what way, need to be re-evaluated and reconstituted in a way that is truly representative of the potential for international collaboration in this field.

This study discursively examined both the extant literature and a specific case analysis of international collaboration. In both phases the definition of ‘collaboration’ was challenging, but seemed to include common elements. This diachronic evaluation of language as a discursive strategy identified discursive practices that may increase the likelihood of effective collaboration due to the fact that they account for intrinsic and dynamic organisational characteristics, such as ‘human elements’ that are unpredictable, inimitable and often quite unique to a given discipline or industry.
For successful collaboration to occur, the construction of language through the discursive elements outlined above and the communication activity that follows are reliant upon certain values and expectations being laid as the foundation to collaborative relationships. It is then possible for these discourses, and the language encompassed within them, to lead to the theories becoming embedded within collaborative practice. When examined through a modernisation lens, the discursive practices utilised to affect successful collaborative activity on the international stage should assert a sense of mutual benefit and advocate for an equal balance of power that is reflected in the organisational structures used to frame the collaborative endeavour.
International collaboration revisited, revised and reconstituted

"History, despite its wrenching pain, cannot be unlived, and if faced with courage, need not be lived again."

-- Maya Angelou (1993, p. 13)

SYNOPSIS

The dynamic and unpredictable nature of collaboration in itself relies heavily on the personalities involved. It relies on what drives and motivates those individuals, and on finding a connection between themselves and others to be able to move forward. There are, however, common qualities and strategies that may be utilised to successfully facilitate collaboration – in particular collaboration that crosses international borders. It is hoped that the discursive journey articulated in this thesis provides some insight into these qualities and strategies and serves as broad guidance for those who seek to establish international partnerships for health and other research in to the future.

INTRODUCTION

International relations and the ways in which groups network, interact and collaborate on the world stage is changing. This, in turn, impacts on the ways in which research projects are undertaken and funded across international borders. It is therefore important to
understand how researchers and policy makers engage with this activity if we are to make the most of its potential to impact on and improve global health outcomes. International correspondence around health care and health research is not a new phenomenon, but it has been timely to examine the ways in which various groups discursively invest in this type of activity – both consciously and unconsciously. The double-barrelled discursive approach utilised for this study (i.e. the use of discourse analysis to examine the extant literature and discourse as a strategic resource) enabled a more rounded perspective on the nature of collaboration and the use of discourse to facilitate collaboration. It provided insight into how discursive strategies can be best harnessed to equip individuals and groups with the information and tools they require in order to successfully collaborate with others from diverse backgrounds to solve internationally relevant issues.

THE ‘LIVED’

As Maya Angelou stated, history cannot be un-lived. As this piece of work draws to its close, it is hoped that the experience and learning unveiled along the way might provide some guidance to others who seek to collaborate on the international stage in any discipline, but with particular reference to health research. The discursive journey undertaken in order to conduct this piece of research revealed and re-revealed intricate and interrelated concepts and ideologies relating to the establishment of international connections and collaborative partnerships that aimed to improve health outcomes. These were sometimes viewed as productive, mutually beneficial and worthwhile endeavours and at other times they were viewed as exploitative, abusive and manipulative.

The methodology and methods utilised for this study enabled me to immerse myself in the various perspectives relating to international collaboration and to understand the
motivations and desires of those who seek to conduct health research on the world stage. A Foucauldian informed approach provided a unique opportunity to examine the power-knowledge implications of efforts to collaborate internationally and to better understand the human experience of international collaboration. Unlike traditional approaches to the analysis of organisations, this approach enabled the deconstruction of notions of truth around the benefits and/or pitfalls of international collaboration and to use these discourses to be both retrospective and prospective about the practice of international collaboration.

Different national and cultural attitudes to international cooperation of this nature were identified, as well as the challenges, complexities and anticipated contributions of various participants in this process. Although visible in the literature to date, there had been no in-depth analysis of this nature that optimised knowledge contained in the extant literature coupled with a unique approach to organisational analysis.

The study revealed the largely discursive nature of both organisations and collaboration in general, and the way in which discourse can be manipulated in various ways to reach specific goals. The discursive analysis of the extant literature, conducted through a colonialist and modernisation lens, made it possible to distinguish a clear delineation between the perspectives of those researchers in developed and developing countries, and the power constructs associated with these two perspectives. These ranged from those who firmly believed in the power of collaboration as a positive force of good to those who fundamentally believed that there was no benefit whatsoever in undertaking this activity.

In addition to this phase of the analysis, the discursive case analysis demonstrated the influential nature of discourse as a resource for the promotion and advancement of
collaborative initiatives. This phase illustrated how discourses may be used and manipulated to control and influence organisational direction and positioning for international collaboration.

The outcome has been the development of a model that works to create a dialogue between those who seek to collaborate across international borders that may facilitate deeper and more meaningful contributions such endeavours.

THE ‘UN-LIVED’

Taking stock of current perspectives and approaches has been a crucial first step with regard to the development of strategies for successful international collaboration. Moving forward, it is hoped that future research might work to establish whether the new model for international collaboration identified in this thesis can be pragmatically and successfully applied. International cooperation, not only in the health research sector but across the board, is a policy goal, and strategic policy frameworks that align the goals of these initiatives would be a potent and legitimate strategy to achieve broad spectrum change.

Access to high quality information regarding collaborative efforts, levels of internationalisation and indicators that enable organisations to position themselves on the international stage for collaboration is challenging. Mechanisms that facilitate the identification of appropriate, desirable groups for collaboration, that align the aims, goals and needs of different groups internationally and that overcome financial and communication challenges are not only required but also absolutely necessary.

There is great potential for the conduct of further research into the experiences of those who drive and participate in international collaborations, both from developed and
developing countries. Cross-border collaboration on health research seems an inevitable and necessary strategy to combat and eradicate disease and illness. The potential for economic and social benefits are significant.

Qualitative assessments are important to this end, but quantitative analysis would also be highly beneficial. Currently, there are few countries with well-developed and defined approaches to the evaluation of policies related to international collaboration and their effects. Thus, there is also the potential to examine the impact of international collaboration on the quality of research outcomes and the impact of international collaborations on clinical practice, decision-making and global health outcomes. In turn, the results of such research may inform priority-setting agendas and international research funding decisions.

CONCLUSION

The ‘wrenching pain’ and ‘courage’ of undertaking a Doctor of Philosophy, for me, is at an end. It seems that international collaboration can confidently be touted as a beneficial exercise if conducted in ways that respect difference and create cohesive and equal relationships across borders. Of course international collaboration is not a new phenomenon, however, this research is a reflection of current discursive themes and approaches relating to international collaboration in health research and a demonstration of potential discursive enablers and barriers to this endeavour.

The model of international collaboration drawn from the results of this study attempts to account for the intricacies of sameness and difference, and to marry this with a
communication strategy that is sensitive to creating a sense of common identity and purpose.
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