A collaborative practice model demonstrates the collaborative nature of work required from medical and nurse practitioners to ensure quality care to patients following sexual assault. The roles unique to each discipline, and the shared knowledge and skill sets, are outlined.

It is this recognition of uniqueness and acknowledgment of shared roles that allows for comprehensive assessment, examination, treatment, documentation, referral, and follow up of survivors.

Collaboration between these health providers supports research and program development initiatives. The model that supports collaborative practice meets survivor and community needs for a comprehensive approach to care, and ensures that knowledge and skills unique and common to both disciplines are used in the care and follow up of sexual assault survivors.

The Regional Sexual Assault Treatment Centre (RSATC), located in London, Ontario, is one of 33 centers funded by the Provincial Ministry of Health to care for survivors of acute sexual assault.

RSATC serves a catchment area of 700,000 people and is located within the St. Joseph’s Health Centre, an acute care teaching hospital affiliated with the University of Western Ontario.

Care is provided by a multidisciplinary forensic team from the disciplines of nursing, medicine, and social work. Acutely assaulted men and women have access to the program through a number of entry points, including self-referral, the local police, health care providers, and community agencies.

RSATC provides immediate and follow up physical and emotional care to persons experiencing an acute assault. Compassionate care is delivered by an interdisciplinary team committed to wellness.

Guiding Values

Figure 1 outlines the organizational values of St. Joseph’s Health Centre. These values provide the overall operating philosophy for the institution and services provided to the community by individual programs. Collaboration is clearly identified as a key component of how work is accomplished.

Figure 2 outlines values identified by the treatment team of the RSATC as essential in the provision of quality patient care for persons experiencing a sexual assault. Collaboration within the community and within the forensic team are specifically articulated.

The advantage of a written commitment to this style of behavior is that members of the team can review the behavior expected to ensure the level of collaboration necessary for optimal patient care.

As well as being a guiding principle for established team members, collaboration is a value discussed at length with new members joining the team. New members are able to make an informed decision regarding team membership, being aware that this style of behavior is an expectation and a resource.

Defining Collaboration

Collaboration is thought to have a positive affect on patient outcomes. Health care teams that strive for a collaborative environment provide higher standards of care than individual practitioners working in isolation (Trueman, 1990). Henneman, Lee, and Cohen (1995) state that collaboration is equated with a partnership characterized by mutual goals and commitments.

Support for the concept of collaboration can be seen in our corporate philosophy as well as in the program's values. Collaboration can be viewed as a move away from hierarchical and traditional relationships based on status to a relationship based on trust and respect.

The dictionary defines collaboration as working jointly, especially with one or a limited number of others in a project involving composition or research to be jointly accredited. We believe that our collaborative efforts provide higher quality service than that which could be attained by choosing one provider over another in a competitive manner. We have defined collaboration as working jointly, caring jointly, and problem solving jointly.

Responding to Victims’ Needs

It is important to consider why collaborative efforts by nurse and medical
practitioners are necessary in the care of acutely sexually assaulted persons. Professionals from nursing and medicine trained in forensic science bring unique and essential knowledge, skills, and attitudes to the care of sexual assault survivors. However, no single discipline, and no individual, is equipped with all necessary responses to care for sexually assaulted persons.

To understand this, it is important first to consider the scope of needs of individuals who have experienced a sexual assault. Figure 3 illustrates many of these biological, psychological, and social needs. Take, for example, a 25-year-old mother of one child who has been sexually assaulted by a stranger while walking through a park late at night. She may require a forensic examination, prophylaxis against sexually transmitted diseases, and suturing of soft tissue injuries. Insomnia, self-blame, thoughts of suicide, and a sense of loss for the freedom she previously knew may continue for months. Her husband and child may feel isolated and confused, and may require support and education regarding her experience of sexual assault.

Follow-up health care

An area of great importance from both a legal documentation and health needs perspective is follow-up health care. The forensic nurse practitioner is an ideal candidate to provide regular clinic hours for follow-up appointments. The survivor of an assault can be given an appointment for examination at both 48 hours and at 2 weeks postsexual assault.

The 48-hour visit provides a unique opportunity to document the status of known trauma and of late-developing bruising. Support needs can be assessed and survivor counseling services organized. The 2-week postassault visit allows for retesting for sexually transmitted diseases as well as for psychosocial assessment. It is not uncommon for the nurse practitioner to consult with the physician regarding antibiotic choice or to request medical assessment for illness concerns.

Unique needs must be met

Sexual assault victims have complex and uniquely individual needs. It is our role to meet their needs. We only can meet these vast needs through a collaborative, interdisciplinary effort.

Antecedents to Collaboration

To understand collaboration, one must consider what antecedents or conditions need to be in place to allow effective collaboration among nursing and medicine in the care of acutely assaulted persons. Participants must display individual readiness and willingness to act, share knowledge, and be available for care. All
must understand and accept his or her role and expertise, and the limits of his or her expertise. Participants must be confident in their own abilities and recognize the boundaries of their own discipline. Participants must demonstrate a willingness to reach out and ask for assistance. Care is based on respect and trust of colleagues and clients.

For a team to flourish, the work must fit with the organizational values, including equal participation in decision making and interdependence. It is imperative to have visionary leaders supportive of autonomy. Baggs and Schmitt (1988) identify that setting goals and assuming responsibility are critical to collaborative success. Sharing of responsibility is essential as is a willingness to address conflict in an open manner.

**Facilitating Collaborative Efforts**

Henneman (1995) noted that other models of interpersonal behavior including competition, compromise, avoidance, and accommodation may replace collaborative efforts. Each mode of behavior reflects varying degrees of assertiveness and cooperation. Collaboration is distinguished by behavior of team members that both is assertive and cooperative. To support collaborative behavior, regularly attended meetings are scheduled to allow team participation and problem solving.

Case Management is a weekly scheduled event that allows team members to review care delivery, identify barriers to care, and plan for future treatment options.

In addition to Case Management, which focuses on individual client care, the Clinical Management committee meets quarterly to identify protocol development, capital equipment, and educational needs of the forensic team.

A Community Advisory committee meets quarterly, enabling input from community members that allows planning on a regional basis. Members represent police services, victim witness programs, and community care provider groups. A sense of collaboration within the community reinforces the work of the treatment team.

The Sexual Assault Coordinating committee oversees the work of the three working groups and provides a critical link with management at the Health Centre. Although these committees appear to be very time-consuming, the team's experience has been that issues are addressed in a proactive fashion, which results in much less rework and a more comprehensive treatment plan. All of these efforts endeavor to deliver high quality service focusing on individual care and service provision to the community.

Other efforts the team uses to support and facilitate collaboration includes the development of multidisciplinary standards. Figure 4 demonstrates characteristics that all team members are encouraged to develop, including advanced problem-solving skills, advanced communication skills, selected diagnostic and therapeutic skills, and clinical decision making based on specialized knowledge.

In addition to these core competencies, nurse and medical practitioners have developed standards for assessment, doc-
umentation of injuries, and treatment protocols. The standards reflect client needs and identify skills and competencies critical to the forensic examiner, whether a nurse or medical practitioner.

Figure 5 outlines the knowledge and skills required by nurse and medical practitioners providing care at the time of client presentation. Further delineation is made to identify the unique skills of the medical practitioner and the unique skills of the nurse practitioner, as well as the skill set common to both. This collaborative model ensures the availability of expertise, responsive to the unique needs of individual survivors.

An informal means of measuring collaboration is the language used by team members when discussing the program. We sense that the use of the term "we" is reflective of collaboration while "I" statements may indicate individual perceptions and goals. This measurement is not intended to override an individual's right to express thoughts and feelings. Decisions must be made in a manner that allows individuals to contribute to the process, although team members ultimately accept personal commitment and responsibility for shared decisions.

**Benefits of Collaboration**

Collaborative efforts have positive results for both the client and individual team members. Here, the client has access to a broad range of expertise, which is immediately available, if the need arises, in both short- and long-term treatment. Meanwhile, the provider experiences less isolation in dealing with an individual's complex needs.

Koerner, Cohen, and Armstrong (1986) support the idea that collaboration results in increased satisfaction for the providers and enhanced satisfaction with their practice. The ability to refer to and consult with responsive team members may decrease burnout, which often is discussed by practitioners working with persons experiencing violence.

**Summary**

Collaboration between nurse and medical practitioners is required to achieve the quality of care needed by persons experiencing sexual assault. The environment necessary to support this endeavor emerges from the larger organizational values, the program values, and from mature, confident team members. Medical and nurse practitioners understand their unique knowledge and skills as complementary and enhancing, rather than divisive; they must identify the knowledge and skill sets common to both as well as those unique to each discipline.

The complex needs of the client demand a collaborative, multidisciplinary approach. This approach benefits both the client and the care provider. The atmosphere provided by this style allows individual professionals to grow and cultivates interest to learn from each other. Modeling of this behavior to clients gives unwritten and unspoken permission to rely on others in a healthy and open fashion.

**References**


