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Discourses of middle managers' cross-boundary collaboration in health and social care

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Abstract

Purpose – In the implementation of integrated care, the role of managers is important and their mutual collaboration should be addressed more visibly. The purpose of this study was to investigate how cross-boundary collaboration is constructed in the discourse of middle-level managers in health and social care.

Design/methodology/approach – The study was based on a discursive approach. Group discussions with three groups of Finnish middle managers ($n = 39$) were analyzed using discourse analysis.

Findings – Five ways of talking about cross-boundary collaboration were identified, labeled "ideal", "structure", "defence", "money" and "support" discourses. In the ideal discourse, cross-boundary collaboration appeared as a "good thing" and is self-evident. Structural discourse defined managers as passive actors in self-sustaining entities. Defensive discourse highlighted the problems of cross-boundary collaboration and the hierarchy within the health and social sectors. Financial discourse constituted the ultimate obstacle to successful cross-boundary collaboration, and both strengthened and explained defensive discourse. Supportive discourse portrayed other managers as partners and as an important resource.

Research limitations/implications – Cross-boundary collaboration can be experienced as a resource, helping managers cope with their workload. However, identification of and continuous attention to challenges at macro, meso and micro levels of integrated care is crucial for successful collaboration. Thus, critical discussion of collaboration needs to be given space.

Originality/value – The study design and discursive approach highlights the power of language and give voice to middle managers who are key actors when implementing integrated care.

Keywords Integrated care, Cross-boundary collaboration, Health care, Social care, Middle manager, Discourse

Paper type Research paper

Introduction

Despite attempts to promote integrated care, the fields of health care and social care in many countries still work in their own silos (Lau *et al.*, 2018; McCullough *et al.*, 2020). In the implementation of integrated care, cross-boundary collaboration between professionals is crucial. However, the role of managers in integrating care has been addressed only recently (Amelung *et al.*, 2021; Elliot *et al.*, 2020; Nieuwboer *et al.*, 2019) and needs more attention. Integrated care will not succeed without committed managers who facilitate professionals' collaboration in practice, show the right direction and provide an example as collaborative actors. Diverse approaches to understanding cross-boundary collaboration are still needed.

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The discursive study presented in this paper focuses on middle-level managers working in the field of health and social care in Finland and brings the voice of the managers to the fore.

The current Finnish context creates an interesting arena for integrated care research. An extensive national-level reform of the health and social care system is under construction (Sote-uudistus 2022). The reform changes the responsibility for arranging the services from many small municipalities to fewer large counties. In future, public health and social care services in Finland will be offered by county-level integrated care organizations, in which the administration and funding of health and social care will be "under one roof". The reform will transform the ways health and social care professionals work together over the existing sectoral, organizational and professional boundaries. It will also challenge managers to rethink their orientation on cross-boundary collaboration. Rather than concentrating on optimizing the productivity of their own unit, managers at all levels of organizations must shift their focus on creating and maintaining connections with other units and sectors, to provide flexible and coherent health and social care for clients. To create a more cohesive care for people with complex needs, a worldwide movement is underway to integrate care. A number of countries have initiated smaller and larger efforts to bridge the gap between health and social care. The challenges that the Finnish managers face, with great probability, may also be recognized by managers in Europe and the world.

The aim of this study was to investigate how cross-boundary collaboration is constructed in the discourse of middle-level managers in health and social care. The research questions addressed were (1) *what* do middle-level managers speak of when addressing cross-boundary collaboration? and (2) *how* do they speak about cross-boundary collaboration?

Managers' collaboration over boundaries – a core of integrated care

Integration of health and social care demands a new kind of orientation of management (Aufegger *et al.*, 2020; Klinga *et al.*, 2016). This has been recognized in the practices of management (Kaehne and Nies, 2021). Cross-boundary collaboration among managers in general has also recently attracted more interest in research (Hsieh and Liou, 2018; Iachini *et al.*, 2019; Fairhurst *et al.*, 2020). In the context of health and social care, collaboration between managers has been addressed in several studies (Currie and Lockett, 2011; Sullivan and Williams, 2012; Van Vactor, 2012; Gibeau *et al.*, 2020). Managers' collaboration is strongly determined by similar factors to those which have been observed more generally in interprofessional collaboration (Cameron *et al.*, 2014; Fox and Reeves, 2015), such as the conditions under which collaboration is engaged in and barriers encountered when working with a diversity of perspectives, identities and interests (Glasby *et al.*, 2011; Willumsen *et al.*, 2012; Morgan *et al.*, 2015; Rämgård *et al.*, 2015; Liberati *et al.*, 2016; Schruijer, 2021).

By managers' cross-boundary collaboration, we refer here to collaboration between managers when they attempt to work constructively with the interdependencies in order to develop better care, and hence, cross boundaries of sectoral, organizational or professional silos while simultaneously dealing with the obstacles accompanying cross-boundary collaboration (Schruijer, 2021). In the literature this is called also collective, collaborative or connective management or leadership (see e.g. Morse, 2010).

Conventionally, management has been regarded as an individual action, drawing on a tradition of a single manager working alone, being responsible for defending the resources of her/his own unit (Bihari Axelsson and Axelsson, 2009; Iachini *et al.*, 2019). The myth of a strong individual manager has been in the core of management thinking (Klinga *et al.*, 2016). Seen from these perspectives, cross-boundary collaboration among managers cannot be taken for granted. In the implementation of integrated care, it is important that the management level is committed and is willing and able to work across the traditional boundaries arising from differences which still exist between health and social care, between

primary and specialized care and between health and social and other related fields, such as the educational sector.

Methods

The study presented in this paper is part of a Finnish research project (Hujala *et al.*, 2020), which aimed to increase the understanding of cross-boundary collaboration between health and social managers and to develop ways of improving it. The project focused on middle managers whose work was related to clients needing services from several care providers. Thus cross-boundary collaboration was part of their work. In the overall project, collaboration was approached from four meta-theoretical approaches: social constructionism, a practice-based approach, phenomenology and critical realism (see Hujala *et al.*, 2019). The study presented here was based on the first of these approaches, social constructionism and the discursive turn.

The participants of the study consisted of three groups of middle level managers working in public organizations. From 39 participants 37 were female and two male, which represents the gender division of middle management in this field. Managers represented social care, health care or integrated health and social care. In addition, there were two managers from the educational sector, which collaborates with health and social care regarding children and family issues. The groups were located in three different regions in Finland and all of them consisted of representatives from different sectors and organizations. Managers worked either in municipalities, being responsible for their own sector's services, or in wider organizations owned by municipalities where health and social care were already integrated under the same administration. Research permissions were obtained from all organizations, as well as signed informed consents from all participants. In Finland, assessment by an ethical committee is not needed for this kind of study.

The material for this study consists of six group sessions and related discussions (5–6 h per session, two sessions for each group), facilitated by the first author, one accompanied by the second and one accompanied by the third author. In addition, three feedback sessions were arranged to discuss the preliminary findings with the participants. All 39 participants took part in these discussions at some stage. Discussions were mainly free flowing; some themes such as pair leadership, change management and values of integrated care were shortly presented by the facilitators to be discussed and reflected upon by the participants. In addition, some of the discussions included artistic elements (e.g. reflections based on pictures shown to the participants). The main part of the group discussions was recorded and transcribed (altogether 300 pages; font Calibri 11, line spacing 1,15).

The discursive approach applied in this study is based on social constructionism (Gergen, 1999; Shotter, 1993): social reality is seen to be constructed in the talk and interaction of people. The definition of discourse adopted is "a connected set of statements, concepts, terms and expressions which constitutes a way of talking and writing about a particular issue, thus framing the way people understand and act with respect to that issue" (Alvesson, 2004, p. 327; originally in Watson, 1994, p. 113). Discourse can refer to micro-level interaction and language-in-use of people or to broader macro-level world-constituting phenomena (Alvesson, 2004). These levels are intertwined: micro-level discourse creates, maintains and changes macro-level discourses and vice versa. Thus, managers' mundane ways of talking about cross-boundary collaboration frames the way they collaborate, and similarly broader societal level discourses frame their ways of talking.

Discourse analysis refers to different approaches varying in their emphasis either on linguistic or social phenomenona (Ismaeel, 2021, pp. 52–58). Various discursive approaches have been applied to address cross-boundary collaboration in the context of health and social care (see e.g. Haddara Wael and Lingard Lorelei, 2013; Jørgensen *et al.*, 2020;

Komulainen *et al.*, 2019; McDermott *et al.*, 2016; von Knorring *et al.*, 2016). In this study, we applied Fairclough's (1992, p. 73) three-step approach. First, we paid attention to text, "what" the middle managers spoke about: what issues they addressed when they spoke about cross-boundary collaboration. At this stage of the analysis, we identified five themes in the cross-boundary collaboration talk: ideality, structures, defence, money and support. Second, we focused on discursive practices, "how" the middle managers spoke about cross-boundary collaboration within these five themes (e.g. what kind of expressions they used when they spoke about structures and how they connected structures to collaboration). Third, we identified connections of these five discourses to broader management issues and their potential consequences [2].

It may be worth stating that various kinds of ways of talking about collaboration were identified even in one person's single account. Thus, our discursive analysis does not take a stand on whether the participants really meant what they said, or whether the discourses we identified were participants' shared perceptions or not. The focus on the language in the analysis is based on meta-theoretical assumptions which assume that social reality is constructed through language, not mirrored by the language.

Results

Five discourses of cross-boundary collaboration were identified from the managers' talk. We labeled these different ways of talking about collaboration as follows: (1) ideal talk, (2) structure talk, (3) defence talk, (4) money talk and (5) support talk.

Discourse 1: ideality – with a cautious suspicion

In the ideal discourse the managers spoke about cross-boundary collaboration mainly positively. There was a lot of rhetoric about the fluency of collaboration and how it is already a part of their work. Working together was described by positive words such as open, openness, natural, genuine and dialog, reflecting a positive stance towards collaboration with manager colleagues. Multiprofessional and cross-boundary collaboration were seen as a "good thing", almost as unquestioned and self-evident.

However, the ideal talk often included a suspicion, which was expressed very cautiously. The talk was often characterized by formulating conditions. In the following extract this is shown by the word "but" and the use of a conditional form.

> But in a sense it would be wonderful [to have] a kind of collaboration that . . . that it would be so low-threshold that you could ask [from the other party] what do you think, could we have more collaboration here . . . (B2) [1]

The positive talk about open dialog often ended up with a question mark and a doubt, an "*openly, but . . .*" orientation. A tendency towards doubt is expressed in the citation below. The willingness to collaborate was questioned, openness was experienced as superficial and insincere and its realization was called into question by the "but clause".

> . . . it appears that we are very open to collaboration, but we are still very much in our own bubble and the collaboration does not take really take place. (B8)

What does the (rather dubious) ideal discourse tell us about management more broadly? In current health and social care, collaboration appears to be regarded as an obvious goal, a meta-level value, even a norm. In general, it is also a salient part of professionality and supposed to be in the core of management skills. Does any care professional have the courage to admit that he/she is not willing to collaborate, or that he/she does not find it useful – even if they actually think like that? Ideal talk positions managers as self-evident supporters of collaboration. If the value of collaboration can be called into question only indirectly,

managers may be too cautious with another. Collaboration may remain at a superficial level, and the real challenges and problems are not addressed.

Discourse 2: structures as a self-sustaining entity

It is quite obvious that managers associated their talk about collaboration with the structural organization of health and social care. Collaboration is either facilitated or hindered by organizational structures (the latter being manifest in separate sectoral, organizational and/or professional silos). What makes the structure discourse interesting is *how* these two issues, structure and collaboration, were discursively linked: managers often described structures as the ultimate obstacles to collaboration.

The vocabulary of structural talk consisted of technical and mechanical terms, such as flow charts, process, process steering, modeling, systematic, processing and boundaries.

> Now we have to learn to collaborate systematically with this group and build some kind of process paths . . . (C1)

Processing and grinding of the structures in the direction that would enable collaboration was called for. The structures were defined incomplete referring by continuous reform processes in health and social care. One manager expressed her frustration referring to the ongoing reform in Finland . . . "*the same brick is laid over and over again*" (B16).

> . . . quite a lot of processing is still needed [in developing collaboration structures] . . . but how will it be implemented in practice so that the walls would drop a bit? (B14)

The structure talk portrays a human being as part of a "technical machine", having no control over how the system works. In terms of cross-border collaboration, this discourse defines the manager her- or himself as a passive actor who cannot influence how collaboration is implemented.

The following extract depicts one manager (working in the already integrated health and social care organization) who described the system as something which operates on its own terms. It sustains itself; things just happen.

> . . . this system starts to build itself – yesterday we talked about, among other things, the need for smooth and client-friendly solutions . . .. And at the same time we are building an organization and system which "feeds itself". Everything always needs to go through some sort of conclave, you can do nothing on your own initiative. . . . so I thought that this is crazy, that by doing it this way we make it impossible. (A6)

To sum up, in this discourse structures are objectified, constituted as an entity and considered to be detrimental for collaboration. The system is expected to be efficient rather than effective, ignoring other integrated care values (e.g. patient-centredness and partnership). The manager's influence on client-oriented collaboration is considered to be limited. The client as an actor may be forgotten if the system works only to serve the organizational structures.

Discourse 3: defending social issues in a health-oriented world

In the defence discourse, collaboration had a negative tone and reflected strong defensive positions of managers. The vocabulary included powerful metaphors that created the image of collaboration as threatening: dumping on, digging into one's own plot, defensive stance. The threat was responded to by defending one's own position. Confrontation and subjugation, subverting equality, were emphasized. Compared to the caution of the ideal discourse, this talk explicitly highlighted the problems of cross-boundary collaboration. Defence was described, for example, as a reaction to experiences of pressure.

> Every now and then you get worried that when the other one keeps pushing, you automatically take a defensive position . . . (B14)

Concrete metaphors were used, for example digging oneself into on one's own plot, which reinforced itself as the other party being denied permission to come nearer. In the following extract the defensive stance was discussed constructively:

> I really liked that discussion where we started to think about what we have in common and what are the benefits, [we discussed] in a positive way, and not in the way that everyone digs their heels as deep as possible: that this is my plot, do not come here. (B15)

The defence discourse highlighted conventional, hegemonic hierarchy between the health and social sectors. The unequal position of the two sectors was emphasized by middle managers: social care was represented as subordinate to health care.

> Whose voice is the biggest voice – quite often it is the healthcare profession's; it's pretty loud, is healthcare's voice. It creates some kind of confrontation, somehow. We often perceive ourselves in social care as being subordinate [to health care]. (Bx)

The defensive position of social care also became evident in the national-level reform preparations. Two managers with a professional background in social care had been involved in the reform work, focusing on integration of the health and social sectors. They felt that their role had been "a defence solicitor of social care in a health-oriented world" (B8). Another manager put it as follows:

> . . . in the reform preparation [when I was involved in the planning of the national-level reform of the health and social care system] my task [with my professional expertise in social care] was mainly to keep a watch on the social aspects, so that they would be taken into consideration in all issues in service integration . . . (C3)

The defence talk revealed confrontation and hierarchical inequalities, which appeared to complicate the cross-boundary collaboration also at the middle management level. These were related either to professional differences or to a value-loaded dichotomy of health and social care sectors. In the defence talk, collaboration was construed as a threat, and managers had to defend their own sector, unit or profession. The consequences of the defence discourse are twofold. On the one hand, manager colleagues are experienced as opposing parties rather than partners. On the other hand, explicitly talking about these problems is important, because admissions such as this help to address them.

Discourse 4: money as a concrete obstacle

In managers' talk, money constituted the ultimate obstacle to successful cross-boundary collaboration. Despite the possible willingness of partners or enabling structures, finance often appeared to be the concrete barrier to effective collaboration. Money talk can be characterized as problem talk with a negative tone. In particular, financial issues were associated with problems of sharing financial responsibility, but also with conflicting goals of the organization.

Money talk both strengthened and explained defence talk. The defence discourse described above reflected the dilemma that confronted managers: every manager is expected, above all, to ensure that her/his own unit's performance is maximized, or at least that the budget is not exceeded. Collaboration over unit boundaries often threatens this requirement. As one of the managers stated: "They [upper management] make us [middle managers] compete with each other." (B6) Thus financial questions positioned collaboration and the responsibility of one's own unit as opposite. The message of the managers was that even though collaboration is considered an important organizational goal at the discursive level, it

is money that dictates a unit's performance evaluations. This may result in a defensive attitude and avoidance of collaboration.

> . . . So, these financial issues . . . and budgeting, it is always the number one issue that in the end puts up boundaries that prevent collaboration. Then we start drawing lots about whose purse these expenses will go from. The client is not in the centre, even though we are talking about the client having to be in the centre, and that we are acting in the client's best interests. (B14)

> Collaboration [succeeds] until we come to the financial issues . . . But then when financial statements are made, the graphs are displayed and it is questioned that can how this be like this, and nobody remembers that during the whole year it has been our common budget. (B15).

The financial discourse included similar "fact talk" to the structure discourse: the shortage of money is "naturalized", constituted as a taken-for-granted fact. Using increasing costs as a threat and sticking to austerity talk may have the result that lack of money is normalized as an unquestioned component of health and social management.

To conclude, negative problem talk about money appears to be an easily legitimized obstacle to managers' cross-boundary collaboration. Middle managers express to be isolated from each other's by "money boundaries": money dictates and has a final say.

Discourse 5: supportive collaboration

Support talk was the most positive of the discourses. Managers' collaboration was illustrated as a valuable resource. This way of talking was in the minority: it was expressed mainly by managers who worked in integrated health and social care organization.

As a background for this discourse, managers talked quite a lot about the work pressures and related exhaustion of middle-level managers. Lack of time and hurry were felt to be very common.

> . . . Last autumn and already last spring I felt that now I do not have enough resources to cope, that work is being left undone and I'm exhausted all the time . . . (A4)

> I claim – and I do not know whether this is too bold an argument, and this is even being recorded – but I am extremely concerned about the coping of middle managers and department heads . . . (A11)

Exhaustion was associated in particular with performance pressures. Good organizational outcomes were achieved, but with the result that both managers and workers felt extremely tired. Managers partly blamed themselves: they admitted that too often they did their work even at night time, because they did not want to be regarded as under-achievers.

In the support discourse, collaboration with manager colleagues was seen positively and regarded as a resource. According to the support talk peer collaboration and "the manager community" provide support and positive power to what is needed in coping with managers' daily lives.

> Compared to my time of [being a manager in a Municipality x], I think [that in this integrated organization] the best thing has been that collaboration between other managers has intensified and I have got new co-workers [co-managers]. Previously, I was just there by myself as a manager. It felt as if I always had to come up with the solutions by myself, and sometimes it went well and sometimes not quite so well. Now it is nice that there is always someone to ask . . .. I know we have a lot of strength, and that cooperation is our strength. (A4)

The most salient consequence of the support discourse is that in this kind of talk other managers were construed as partners: they were considered as an important resource. Cross-boundary collaboration was seen as a positive phenomenon with positive results.

Discussion

This discursive study aimed to investigate how cross-boundary collaboration is constructed in the talk of middle-level managers in health and social care. Five ways of talking about managers' cross-boundary collaboration were identified: ideal, structure, defence, money and support discourses. The discourses seem to address familiar collaboration issues, but the point here is to highlight what kind of social reality the discourses produced and what are their consequences are.

In general, the ideal talk of collaboration was quite dominating, particularly in the beginning of group discussions. The ideality of collaboration can be regarded as a double-edged sword (see Dickinson and Glasby, 2010). On the one hand, managers' positive stance towards cross-boundary collaboration is a good starting point to realize collaboration in order to enhance integrated care. On the other hand, if the positive stance is maintained and collaboration partners remain in their comfort zone, real problems may not be identified. Fruitful collaboration cannot be reached by avoiding conflicts. As Fishbacher-Smith (2015, p. 197) states, over-optimistic orientation "can create a false basis on which to work" and result in accepting counterproductive partnership policies without calling them into question. Gibeau *et al.* (2020, p. 465) point out that collaboration "is often most needed where it is most difficult to achieve". They conclude that maintaining and even mobilizing tension is the way to enforce fruitful collaboration. Optimism or simply a positive stance may be a necessary condition (people need to want to collaborate), although certainly not sufficient. What is needed is willingness to work with the (sectoral organizational, professional) diversities and engage in constructive conflict – which generally is difficult but there is no way around it (Schruijer, 2021).

The defence discourse, for its part, suggests that managers often seem to stand firmly behind their own position as experts and professionals. Regardless of the reason for defence, this kind of talk has to be taken seriously. How can we expect that care workers will be ready and willing to strive towards common goals and in doing so overcome boundaries, when managers only defend their turf? An individual manager may not be willing to engage in cross-boundary collaboration, because he/she thinks it may be a risk for the success of the unit he/she is responsible for. Bihari Axelsson and Axelsson (2009) call this kind of behavior protecting one's own territory. The solution for this problem would be to alter the performance measures of managers to include "softer" issues so that the added value of collaborative activities would be part of the assessment of managers. However, it also needs to be realized that collaboration across boundaries always involves tensions (and thus defenses and other dynamics), as the collaborative parties do not merge but maintain their (relative) autonomy: they need to (a) collaborate and work with the interdependencies, while also (b) serving their own organization's or unit's interests. Successful collaboration implies realizing a jointly defined goal – a realization which also serves (in a "good enough" manner) the constituent parties' own interests (Schruijer, 2021).

The money and structure discourses suggest that concrete obstacles to cross-boundary collaboration, such as structural arrangements and "money boundaries", create frustration and feelings of powerlessness in middle managers. Losing the feeling of being able to influence one's own work – which may occur especially in large integrated organizations – may diminish middle managers' willingness to actively engage in integrated care. Motivated and supportive managers, however, are a key to the successful implementation of integrated care. Unfortunately, middle managers themselves are often too busy and exhausted. This matter needs to be taken seriously. The supportive discourse offers novel insights to face this challenge. Collaboration seems to enable peer support, which helps in tackling pressures threatening middle managers work.

To sum up, based on the findings of this discursive study, the potential of cross-boundary collaboration appears to be embedded in a basic positive stance towards collaboration in general and in the peer support it offers. This is, however, undermined by structural challenges, differences in professional backgrounds of partners and the differences of care sectors (Auschra, 2018; Goodwin *et al.*, 2014). However, tensions, lack of trust, defence mechanisms and other dynamics are "normal" elements in cross-boundary collaboration (Schruijer, 2020, 2021), yet nevertheless to be worked constructively. Interpretation of integrated care emerges from complex social processes and is based on long-running debates about diverse complex issues (Hughes *et al.*, 2020).

Conclusions

"The power of discourses" remains often unnoticed in leading and implementing integrated care. Middle managers' mundane ways of talking about cross-boundary collaboration are pierced with hegemonic discourses, such as the self-evident value of collaboration, domination of money and structural constrains. These need to be recognized and addressed. By revealing commonalities and truisms embedded in discourses of collaboration it is possible to make key restrictions in developing collaboration apparent. This discursive study suggests paying attention to the following key implications for integrated care:

(1) Critical voices regarding the ideality of collaboration should be given space. The ideal talk of collaboration deceives, because managers are also exposed to defence when they encounter professional and sectoral differences. One solution is building leadership training, development and education, preferably health and social care managers together, to cover issues such as unconscious self-limiting beliefs, stereotypical thinking and other defensive mechanisms.

(2) The role of middle-level management is crucial in the implementation of integrated care. The structure and money discourses highlight frustration faced by middle managers. These deserve attention from top management. Building a collaborative listening culture is needed to develop reciprocal interaction between the top and middle management.

(3) Collaboration entails a potential of empowerment. Therefore, peer support should be utilized by developing manager communities and encouraging peer interaction. At its best, cross-boundary collaboration is a resource which helps managers in coping with their workload.

Further research is needed to address the ways how other key stakeholder groups, such as front-line professionals and clients talk about integration and cross-boundary collaboration. Giving voice to the collaborating actors themselves and relying on the power of words – the social construction of the reality – is one way to increase an understanding of the diversified nature of integrated care.

Limitations of the study

The study is based on research material gathered in one country, Finland, and is contextually linked to the ongoing reform of the health and social care system. The study focused on middle managers only. The authors recognize that the study itself, based on social constructionist study design, produces one kind of reality dependent also on researchers' own orientation; other researchers could end up with different kind of interpretations.

Notes

1. Notes regarding the extracts from the data: A,B,C = three groups of the participants; numbers with A, B, C = identified persons within groups; R = Researcher (the first author); N = participant, not identified, numbers with N refer to different persons (different voices but not identified from the recordings who the person was); . . . = text left out from the citation; [ ] = information added by the first author in order to make the extract more understandable.
2. Authors' contribution: Facilitation of group discussions: AH, SL, HT; preliminary analysis: AH; cross checking analysis: SL, HT; interpretation of findings: all authors (SS and CK present in two group meetings in which preliminary findings were discussed with the managers); conclusions: all authors; writing the article: all authors

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