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Perceptions of Podiatrists and Physiotherapists Working Together in the Musculoskeletal Service

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Abstract

Physiotherapists and podiatrists are working closer together in musculoskeletal services than ever before. This study aimed to look at the role of each profession within the musculoskeletal team, issues of role overlap and professional boundaries and the effects of working together has had on their practice. Their opinion was also sought on the future of both their role and the musculoskeletal team.

The study was a qualitative design using a hermeneutic approach. There were four participants, two from each profession, who work closely with the other profession. Data was collected through semi-structured interviews and a focus group.

The findings from the study were wide ranging. All participants enjoyed working together and felt this had improved patient care. They value a team approach based on equal status and appreciation of skills between the professions. Blurred boundaries and areas of role overlap exist between the professions. Government initiatives are treated with mistrust and are seen as attempts to undermine the professions' current role and status. Consequently there is a resistance to change of role. Conflict with the medical profession and the Allied Health Professions was uncovered. Interprofessional education was initially seen as having little value, but the participants did agree that it could be beneficial for producing effective team workers.

Further research is needed in this area as this is a small study and the findings may not be representative of a larger population.

Introduction

In an attempt to breakdown professional boundaries and redefine roles 1-3, Allied Health professionals (AHP) have been challenged to be open to change "in the way they work, in the roles they play and in the care they give" 4. There has also been a growing recognition that health needs require the collaboration of a team of health professionals to provide high quality patient care 5, 6. This drive for collaboration has led to many published studies across many disciplines which highlight the success of the multi-disciplinary team in improving patient outcomes 6.

Within podiatry and physiotherapy there are many examples of good inter-professional working in practice with positive outcomes for patient care 8-13. However none of these studies make real comparison with previous forms of working to show clearly the difference inter-professional working has made to patient care. A widespread literature review for this study could find no published evidence that had looked at physiotherapists and podiatrists working together.

The Musculoskeletal Services Framework 7 calls for a shared care approach. It is based on the principles of understanding patient needs, use of multi-disciplinary teams, use of specialist expertise and integration and co-ordination of care across boundaries. Both physiotherapy and podiatry are named as professions that, having contributed to musculoskeletal services, will be required to develop this service further.

Podiatry and physiotherapy have sought professional status by claiming a specialised body of knowledge and skills that recognised as part of their traditional role. Both professions have received protection of their titles in law and closure of their professions under the terms of the Health Act (1999)15 and its subsidiary legislation the National Health Service Reform and Health Professions Order (2002)16. Carrier & Kendall 17 state that distinctive qualities of professional knowledge are functional for the profession, rather than for the client and the wider community. They further suggest that the

professions are a form of cartel that hold the exclusive right to offer specific services and this is maintained by the state. Professionalisation stresses the differences rather than similarities between the professions. The boundaries between professional groups are developed and maintained through claims of competence when dealing with specific problems 18. The professionalisation of AHPs increased in the latter part of the twentieth century due to pre-registration training changing from diploma to degree and the growing research culture with Masters and doctoral qualifications in allied health subjects. This has occurred, paradoxically, at a time when medical autonomy has been under attack from government policy, increased service user rights, increased public awareness of medical knowledge and exposition of fallible medical practices 19.

Physiotherapy has further developed its role within musculoskeletal medicine with the emergence of extended scope practitioners (ESP). These ESPs have taken over roles that are traditionally seen as medical roles and have been shown to successful regarding patient satisfaction rates 20-22. The Musculoskeletal Services Framework 7 is looking for ESP physiotherapists to have a major role in the development of these services.

The role of the podiatrist within the musculoskeletal team is based around podiatric biomechanics and management of musculoskeletal injuries using functional orthoses 7. This has been a major expansion of the professional boundaries of podiatry 5 and is based upon theories developed by podiatrists themselves 23-26. The treatments used have been shown to have a high degree of patient satisfaction 27 but further research has shown that the theories underpinning it may be flawed 28, 29.

Both professions deal with musculoskeletal injuries, physiotherapists treat the trunk, upper and lower limb and podiatrists concentrate on the foot and lower limb. Hence there are areas of role overlap between the two professions in the treatment of lower limb musculoskeletal injuries. The Quality Assurance Agency benchmark statements for podiatry and physiotherapy 30, 31 have many similarities regarding core skills such as communication and

assessment. Hence, both professions have the capabilities to undertake some parts of the others role

Also the Health Professions Council (HPC) standards of proficiency for both professions 32, 33 have many similarities and would expect a podiatrist to use appropriate physical therapies and physiotherapists to understand biomechanics. This suggests that both physiotherapists and podiatrists should be able to treat musculoskeletal conditions and understand the biomechanical abnormalities.

There has been no published research looking at the possibilities of role overlap and changes in role between these professions. Smith & Roberts 34 conducted a study that looked at areas of role difference, skill sharing and commonality between physiotherapy and occupational therapy. It found that service users cannot easily distinguish between the professions and that skill sharing and role overlap frequently occurred. It concluded that the therapists felt that collaboration with the other profession was the most effective way to deliver a good standard of patient care. A greater emphasis must be placed on interdisciplinary working in pre-registration training. Many authors who agree that for healthcare professionals to become good collaborators and competent team members then learning about inter-professional working needs to start in pre-qualification education 5, 6, 35 and this view is supported by the Department of Health 4, 14.

It has been suggested that changes to healthcare delivery will mean that the current structure of professions may not be sustainable 36. The rationalisation of the healthcare professions is inevitable it is how this process takes place that is debatable 35. It is in this context that podiatry and physiotherapy are working closer together within the musculoskeletal team.

The aim of this research was to study podiatrists and physiotherapists working together in musculo-skeletal clinics to see how government initiatives 4,7,14 have influenced clinicians' roles, their understanding of inter-professional

working, changes to their practice and subsequent improvements in patient care.

Methodology

This research study investigated physiotherapists and podiatrists working together in the musculo-skeletal team. The effects that working together has had on their practice was explored. It looked at their role within their musculo-skeletal team, the issues of role overlap and professional boundaries. An opinion on their future role within the musculo-skeletal team was sought.

Research Approach

This project explored physiotherapists and podiatrists experiences of working together, therefore a qualitative method was most appropriate for this project, as it aims to make sense of, or interpret, phenomena in terms of the meanings people bring to them 37,38. A hermeneutic phenomenological approach was used by the researcher. Phenomenology has its roots in the philosophy of Husserl (1859-1938), which introduced the concept of lived experience and that description of these experiences through a process of reductive interpretation would reveal the essence of a phenomena 39. It is directed to the participants' subjective perceptions of their own experiences 40. The concept of bracketing is fundamental to Husserlian phenomenology. Bracketing is when the researcher puts aside any preconceived notions about phenomena so the phenomena can be revealed in its essence, leading to objectivity 39-42.

Hermeneutic phenomenology was initially a progression of Husserl's work by his pupil and colleague Heidegger (1889-1976) and was further developed by Gadamer (1900-2002) 39-42. Heidegger differed from Husserl in the concept of the being having a pre-understanding and background that presents a way of interpreting and understanding the world. It is this concept of the 'being-in-the-world' that we cannot eliminate or bracket 41, 43. Gadamer 44 took this further to say that to try to eliminate one's own concepts in interpretation is not only impossible but also absurd. He also believed that the researcher was part of the process and there is a 'fusion of horizons' between the researcher and participants that allows an act of understanding to occur.

The researcher is a podiatrist who has worked closely with physiotherapists running a multi-disciplinary musculo-skeletal clinic in the NHS. He is now a podiatry lecturer with involvement in inter-professional learning. He has good working relationships with many physiotherapists and has a positive view of this profession. It would be difficult, and to follow Gadamer may be impossible, to disregard the researcher opinions and experiences. Since this will influence all areas of this study, it seemed logical to take a hermeneutic approach, in which the researcher becomes part of the enquiry process whilst acknowledging and guarding against the effects of researcher bias. Previous experiences will allow the meeting of 'horizons' to take place and thus understanding will occur. This approach would allow the experiences and understanding of the researcher about this topic to reveal the phenomena through interpretation of the experiences and perceptions of the participants.

Methods

This study used two forms of data collection, semi-structured interviews followed by a focus group of the participants. This form of data triangulation is intended to enhance the rigour of a study 45, 46. The use of focus groups to follow –up interviews can explore issues and clarify areas where there are differing viewpoints 47.

Initially, the data was collected through a semi-structured interview with each of the participants. Such interviews are a way of uncovering and exploring the meanings that underpin people's lives, perceptions and behaviours 45. Kvale 48 states that interviews are the main method of collecting data for phenomenological research, with a unique potential for obtaining access to and describing participants' lived experiences.

The interviews were semi-structured with an interview guide based upon the aims and objectives of the study to allow similar data to be collected from the participants, but also to have the flexibility to explore issues as they arose in the interview. This type of interview allows the interviewer to follow up ideas,

probe responses and ask for further elaboration and informants can answer questions in terms of what they see as important 45. The researcher made notes during each interview about participants' reactions and the researcher's thoughts on the process and these have been included in a reflexive journal.

A focus group took place two weeks after the final interview to further discuss the findings and emerging concepts of the initial interviews. Focus groups are a form of group interview that capitalises on communication between participants to generate data 49. Focus groups as a follow-up to individual interviews can also be used to clarify areas of difference and, most interestingly, to get group responses to quoted statements from the interviews 47. The researcher used the data collected from the interviews to establish a consensus between the participants, clarify the areas of disagreement and to generate discussion.

Sampling

The main sampling was purposive. Purposive sampling enables the researcher to sample from a population that will address the needs of the study 46. The guiding principle for selecting the sample in a phenomenological study is that all participants must have experienced the phenomena under study and be able to articulate their lived experience 50.

The criteria used selected participants who were physiotherapists and podiatrists that work together and with other professions in a joint musculoskeletal clinic. This automatically limits the number of each profession who can be included in this study. The numbers were further limited in that ethical approval was sort from the NHS Local Research Ethics Committee (LREC) which means that the participants had to work within the same LREC area. In the study four participants, two podiatrists and two physiotherapists, met the criteria within the LREC area, three female and one male. The participants were volunteers who were invited to take part by letter accompanied by an information document. The participants gave written consent to be included in the study.

The study gained ethical approval within the University ethical framework. It also had COREC approval as it involved NHS staff and approval was sort from the Local REC covering the area in which the participants work. Approval was also gained from the Trust R & D department where the participants work. The line manager of each of the participants gave permission to approach them to take part in the study.

Data Collection

All the data, from both the interviews and focus group, was collected digitally, stored as MP3 audio files and transcribed in full. Transcription was done by a professional typist who did not know the participants and was advised about confidentiality regarding the data. The researcher checked the transcriptions t thoroughly against the recordings and amended any errors or spelling mistakes.

A research helper was present at the focus group. It is recommended that one researcher should facilitate the group while the other takes notes and checks the recording equipment 47 50. The helper was a colleague of the researcher who has had experience in qualitative research and has ran focus groups previously. Notes were taken on group interactions, body language, behaviour and emotions and the recording equipment was monitored.

Data Analysis

Analysis began with listening to the audio files, then analysis of each individual transcript by reading then re-reading and re-listening. During this process the researcher referred back to the reflexive journal to revisit his thoughts and impressions from the original interviews. The notes from the focus group helper were matched against the transcript of the focus group.

The initial step of analysis was to develop thematic categories to code the transcripts; this form of editing analysis style is widely used in phenomenological and hermeneutic studies 50. These categories were based

upon the questions used in the interviews and focus group which link to the aims of the research 47.

The researchers used Colaizzi's procedural steps to create a sound framework for analysing data. These steps have been used successfully in nursing research 40 50 51. Each transcript was then coded with the thematic categories. Significant statements were extracted from the transcript and matched to the themes. This was then interpreted into a restatement of meaning. The meanings for each transcript were then integrated together to give overall theme clusters which formed basis for the discussion. Each participant was sent a copy of their individual transcript, the focus group transcript, the significant statements, the restatement of meaning and the theme clusters and asked to comment on the accuracy of the data and its analysis. This is the final step of Colaizzi's procedural steps and is part of the process of member checking.

Trustworthiness

During any qualitative research study is important that the data can be verified as trustworthy 48 50 51. A reflexive journal was kept throughout the whole of the study by the researcher. This can used to guard against researcher bias as it allows the reader to examine the researcher's thoughts and understanding of the participants 48. This reflexive approach is fundamental to a hermeneutic approach to phenomenology 50, 51.

The process of member checking reduces the threat of researcher bias as the participants can verify the researcher's actions. It is a check that the participants feel the interpretation is a true and fair representation of their perspective 51. Each participant checked their own transcripts and data analysis. Three of the participants felt that the interpretations were valid and did reflect their view of working with the other profession. One participant initially, was unhappy with some of the interpretations. After discussion between the researchers and the participant the interpretations were accepted and were left unchanged.

Discussion of the Main Findings

The findings from the interviews and focus group were wide ranging. The focus group was used to confirm the initial findings from the interviews by initially reviewing the emerging themes from the interview data.

Current roles

The interviews began by asking the participants to describe their role and the role of the other profession. The role of the podiatrist was clearly defined by all the participants. Their role within the musculoskeletal team is to assess the biomechanics of a patient and treat them accordingly usually with functional orthoses. The role of the physiotherapist was not always as clearly defined. The physiotherapists tended to use the term 'physio' to describe what they do as if this is self explanatory. This suggests that they view their role and profession as the same, that physiotherapists do physiotherapy. The parts of their role that have extended their scope of practice were defined. The podiatrists were more specific in their definition of a physiotherapists' role, but were unsure that their definition was correct.

This also shows that the professionalisation of each profession is complete as they claim areas of exclusive activity and recognition that they are experts within that field 17. There is an implication by the participants that the podiatrist is the expert for biomechanics and that physiotherapy should be done by the physiotherapist. It also highlights the boundaries that professionalism brings as each reinforces the other professions area of expertise 18.

Interprofessional Working

Between the two professions there were widespread areas of agreement particularly around a combined approach and that team working is best. There is mutual respect and appreciation of the other profession's skills.
The participants believe there is equal status between the professions. There are external factors which contribute to this belief; the rationalisation of the pay structure within the NHS called Agenda for Change has brought the AHPs

pay into line. It also outlines a framework of roles for AHPs which emphasizes the need for clinical specialism, clinical leadership, involvement in policy development and expansion in roles and responsibilities 52.

There was reinforcement of the traditional roles and the importance of a combined approach within a team approach. It is this team approach that makes the best use of the different skills of each profession. There was a clear endorsement of a team approach and effective team working is based upon clear understanding of your own functions and appreciation of the contribution of other professions. There is also a satisfaction from knowing what is expected of you in your position and understanding the relationship of your position to others 53. The professions are experts within their field and have depth of knowledge, again this claim of expertise that goes with professional status 17. The importance of specialising within a field was paramount. There was resistance to change these roles as these are perceived to be hard won. Government initiatives are seen as impractical and attempt to devalue the experience gained by the professions. This confirms Carrier & Kendall's 17 view that changes to health policy will lead to deprofessionalisation and de-skilling with the inevitable consequence of dilution of standards and quality.

Phys 1: erm, so me specialising to the podiatrist's level in biomechanics wouldn't help me when I'm treating my backs my necks my shoulders my elbows and everything else, there wouldn't be any mileage in for me when there's somebody else who can already do it I can't be master of all trades it's just impossible despite the government's wishes

Phys 1: even within our own professions we have I mean we have a specialist physio who just does backs; we have a specialist physio who just does knees you know
Phys 2: that's already a specialism within a specialism
Phys 1: yeah and that's a specialism within musculoskeletal you've got general musculoskeletal physios and then specialist plus you've got all the other specialisms as well you

know how could you possibly one person do everything
Pod 2: respiratory physio, musculoskeletal physio, paediatric physio
Phys 1: yeah, you'd have to train for about 15 years

There was clear differentiation between the value of training and the value of experience. They had become experts not just through training but through experience and this was of greater value. Anybody with training could be given the skills to undertake tasks but this did not make you a good clinician. The participants place greater value on their experience and training than on the other professions' experience and training. This as a by-product of professionalisation that a combination of power over a particular body of knowledge and skills, underpinned with a specific value base allows a profession to assert a unique perspective upon their clients 35.

A: right erm and so what would you say so, so would there be a difference then you'd expect
Phys 2: between me doing and the podiatrist doing it
A: yeah
Phys 2: probably in the assessment
A: in the assessment, right, but like I said if she got further training then erm would you be happy for her to do that
Phys 2: to assess probably not fully
A: why?
Phys 2: because I could do it better
A: so ok why can you do it better do you think?
Phys 2: because I've got more experience

Role Overlap

There was agreement that there is some role overlap between the two professions. The initial reaction was that this was a positive development and could be of benefit to patient care. There is an admission that there are some skills that are generic between the professions and each profession accepts that the other could undertake treatments that are traditionally seen in the others' role.

Pod 2: if I had a drive to sort of place myself in a knee speciality then yeah I mean musculoskeletal medicine is fairly universal erm your assessing a synovial joint your assessing a synovial joint the only factors that change are it's range of movement and function,

Phys 2: yeah, I know that the podiatrist does give stretches and stuff

There were differing views about the boundaries between the professions that emerged during the study. The reaction of the participants to a question about boundaries was to say that it was difficult to describe and that they did not think there were any specific boundaries.

Discussion during the interviews revealed that each participant had a definite opinion of the boundary between the professions. There was general agreement that this was around the knee. Above the knee was seen as the physiotherapists' domain and these muscles below the knee should be dealt with by the podiatrist. It is not surprising that the participants think in terms of an anatomical boundary as podiatry has developed its self as a profession by being seen to be an expert of the foot and ankle 54. This is reinforced by the NHS 7, the regulatory body 33, and by their pre-registration training 31. It is also a sign of professional demarcation with claims of expertise and specialist skills over certain specific areas 18. More surprising is that the physiotherapists appear to support this, as this would appear to diminish their scope of practice and role.

Phys 1: well, I'm quite happy to triage all the ankles and all the feet to the podiatrist

A: Boundaries, the knee would seem to be the boundary
Phys 1: the cut off point
A: would you all agree with that, that
Pod 2: yeah
A: above that the Pods don't feel confident below that the Physios' tend not to feel as confident and feel more confident with the podiatrists dealing with that, yep, ok
All: yeah

A more complex view emerged during the focus group that this boundary was not fixed at all and there was definite blurring of roles. Both professions treat plantar fasciitis despite that previously they had all agreed that the foot should be dealt with by the podiatrist. The relative lack of success of treatments for this condition means that boundary between the professions becomes blurred.

This issue of a blurred boundary would account for the initial reaction from the participants of not being sure of if or where there was a boundary. There were also issues of control of the boundary. There was the underlying theme that each profession has the knowledge and experience in their own area. It was acceptable to cross this boundary if the other profession requested it and was in agreement. There was agreement of the team approach that makes best use each professions' attributes is the most effective. There was an essential element missing from this discussion the client. As the participants seem to be agreeing that neither profession treats the condition well so combined it must be better. Concerns were raised by Long et al 55 that though a shift from professional focus to a team approach is desirable this should not be at the expense of client centred care.

Comments made by both professions about boundaries and role overlap show that in the future that these could be areas of conflict. At present the participants are happy with the status quo and that role overlap occurs with both professions agreement. Previous studies have all found that professions accept role overlap only on their own terms 34, 55, 56.

Role expansion

The need and motives for professions to work outside of their normal role was questioned. There is an emphasis upon a team approach and use of the professions' expertise in their specialist area. These negative comments highlight the underlying fears of change within their roles and possible outcomes for their profession. There is an underlying suggestion that extending your role is detrimental to the team as a whole. This view was

shared in Long et al 55 study where role expansion was seen not as an attempt to improve patient care but an attempt to encroach on the work of other professionals.

> *Pod 2: it's up to the individual commission I mean if I was a different person and I wanted to get into doing knee assessments and managing knee problems on my own then yeah I could created an overlap very quickly, but er depends whether you want to you want to go down that route and whether there is something achievable out of it which is not personal aggrandisement or personable gain or personal advancement or your looking to use the team as a team and use the strengths of the team*
>
> *Phys 1: so, I think you know think to have everybody doing the same thing is just stupid*

There was reinforcement of the traditional roles and the importance of a combined approach within a team approach. The professions are experts within their field and have depth of knowledge, again this claim of expertise that goes with professional status 17. This depth could be lost as they have a broader knowledge base.

There was a view that present roles should be maintained and there was resistance to change. Negative comments were expressed about the future suggesting general unease about government initiatives in this area 3-4. Many published articles talk about the rationalisation and merger of professions 35, 36, 57, 58. These have contributed to the unease of the participants about the breakdown of professional barriers and redefining of roles and that hard fought gains in status power and autonomy will be lost 35. Fears surfaced that working together may aid the breakdown of roles and lead to the loss of specialisms in creating a generic therapist 19. There is also the question of the motivation for these changes and who they will actually benefit. The participants see themselves as guardians of the best interests of the professions and their clients. This paternalistic view of their role is at odds with the growth of client-centred services using the language of partnership with service users 35. It has been shown that service users are more

interested in receiving appropriate care than if the most appropriate profession is giving it to them 34. This would change if uncertainty over professional identity did lead to drops in the standard of care and compassion to patients 59. The participants believe that the most appropriate care is given by a specialist with expertise in that area.

> *Pod 2: yeah, I think you got along the lines of ok, you go along the lines of a generic therapist who basically does a little bit of everything you know covers the whole gambit and you try and replace individual therapist with this one single sort of therapist how long is it before the generic therapist starts to think I would quite like to specialise in doing hips cos I'm quite good with hips you're obviously you're just going to start breaking up into specialities anyway once you pushed everyone together into this one group there's inevitably maybe 50 years down the line starting to split into specialities there gonna be the generic specialist for feet and the generic specialist for knees*
>
> *A: do you think the roles of your professions will alter in the future*
> *Phys 1: not if we have anything to do with it*
> *A: laughs*
> *Pod 2: I think you would have to see what would be gained from it and not just a diluting of the roles into an amorphic sort of therapist*
> *Phys 2: I think the only, sorry*
> *A: go on*
> *Phys 2: I think the only way you do that is get very, very specialised and say I could be a paediatric physio come podiatrist musculoskeletal and leave it at that and I do not touch anything above the knee*

Future of the Team

All participants viewed their work within the team as positive and groundbreaking. They had extended their practice and this was seen as not just positive for their personal development but also for the development of their profession. They also believed that by improving the team approach then patient care would improve further. There is a concern that by extending

their scope of practice it will, in the future, be difficult to replace them and that steps need to be taken to prepare for this. It has been suggested that in the future the professions should be structured like this; a team approach where the needs of the client are paramount and the professions sharing and transferring of some knowledge while claiming and retaining other specific areas 17. This whole process would be underpinned by interprofessionalism education at both pre- registration and post-registration levels. This vision of the future would appear to be supported by these participants. There were concerns that the future of the team would not be in their control that economic issues and other professions outside the team could mean no future for these teams. There is a consensus that government initiatives are looking to reduce the status, power and autonomy of the professions in the modernised NHS 35.

Conflict with Medicine

This was not a theme that the researcher expected to be looking at, but the focus group discussion went into this area. The view was held that health professionals are learning to work together but that doctors are not part of this process. There were many negative comments about the medical profession and its attitudes. Podiatry and physiotherapy would appear to work well together on the basis of equal status and mutual respect. The lack of equality between AHP's and doctors has lead to misunderstanding, mistrust and reinforcement of stereotypical views and attitudes. These views are held about the medical profession as a whole and are a manifestation of the fear of the future for the team. It is characterized by differences in professional status, lack of mutual trust, stereotypical view of role and communication failure. It could also be a sign that AHP's are looking to extend their scope of practice further into areas usually seen as medical roles and they are worried that doctors may prevent this. In contrast to these views about the medical professions, individual doctors are seen in a positive way suggesting that better communication between doctors and AHP's may lead to resolution of this conflict. Pre- and post-registration interprofessional learning has been recommended as a way that can breakdown the barriers between professions 34, 55.

> *Pod 2: Once again, it's it depends on the survival of things like intermediate care sort of ideas isn't it really having these outpatient departments in the community where your gonna have groups of people working in the same environment from different disciplines all sort of prepared to share practice and the longer that goes on then it will accelerate and will grow but not coming down and so being the big money aspect politically that's the only thing that's going to decide whether it stops where it is its based upon somebody making an arbitrary decision based on what what could really pull the plug on this is GPs commissioning once a GP says I'm not going to refer my patients to the Centre I'm not going to refer them there I want them to see a Consultant Orthopaedic surgeon it may only be plantar fasciitis and an Orthopaedic Consultant may only just give them an arch support and a steroid injection which may or may not be beneficial that's the way they will go, cos that's the way the GP's cos they're part of the British Medical Council and they just look after themselves and they will*

Pod 2: never engage, never engage so you're stuck with a medical model at the top
Phys 2: we're on this level below
Phys 1: I think as therapies, I think Nursing and therapies do work well together and I think there be a lot of bridges over the last few years in particular, erm, but I think the sticking point is always the medics
A: right, why
Phys 1: there not all like that
Pod 2: no, no I think some of them are very approachable and very accommodating but you ask them to get involved and they sort of like oh well
Pod 2: therapists aren't part of their team, they don't really understand therapists I don't think, somewhere they don't come from, they don't fit in the model
Phys 1: we're an enigma
Pod 2: yeah
A: laughs
Pod 2: we don't fit in their hierarchical structure

These views draw attention to the concerns that the participants have over GP commissioning. It also reinforces the view that government initiatives do not have a positive affect on the participants role.

Interprofessional education

The first reaction of the group was negative and traditional views about the differences between the professions were raised. Concerns were raised when talking about the future, the loss of expertise and specialisms within each of the professions. The view, which has been suggested as being anecdotal 35, that interprofessional education will lead to the introduction of generic workers was expressed. This again highlights the underlying fear of change that participants have which may mean the loss of the progress they feel they have made in recent years. Some positive aspects of shared learning were voiced. Learning about other professions could facilitate working better in a team and multidisciplinary approach. They support the view of the literature 5,6,35 that this should make future professionals more effective team workers who can easily adopt a collaborative approach. They

can see the benefits of learning together but there is concern that this does not mean that all the professions are the same.

Limitations of the Study

The findings are specifically related to a small number of podiatrists and physiotherapists who work together in two different teams within the same NHS trust. The numbers were limited due to the small number of each profession that are working together in musculoskeletal teams. Therefore this sample is not representative of the two professions. This was restricted further by the fact that the participants had also to work within the same LREC area as this made applying for ethical approval a simpler process for the researcher. This decision does mean that the issues raised in this study may relate to particular concerns within the participants' trust. Qualitative studies do not need a large sample size as there is not the same need for generalising as quantitative studies 51. The study did produce interesting data but the small sample size does make it difficult to establish whether the findings could be transferred more widely or just the view of a minority. Further research is needed using a larger sample size that is more representative of both professions. This would then enable researchers gain a greater understanding of these professions working together.

Conclusions

The Musculoskeletal Services Framework 7 has outlined the future for multidisciplinary teams working in this area. Physiotherapists and podiatrists will have key roles in the new CATS, and will be working closer together. This study looked at podiatrists and physiotherapists working together within a musculoskeletal multi-disciplinary team. The participants feel they have extended their scope of practice, have learnt from working with another profession and feel that they have improved patient care. The patients' benefit from shortened waiting times and use of a combined approach to treatment. These benefits are only perceived since neither team has done any clinical audit or research.

The participants are strong advocates for a team approach that utilises the skills of each profession to give the patients the best treatment. This team approach is based upon equal status between the professions, mutual trust, good communication and excellent personal relationships between the participants.

There are areas of role overlap and blurred boundaries between physiotherapy and podiatry. Initially it appeared that there was a definitive boundary between the two professions, but the boundary was much more complex. Since the benefits and motivation for change have not been justified in the participants' eyes, there was a strong sense of a resistance to change of role. An underlying fear of government initiatives persists in this area and a view that such initiatives are about weakening the status and power the professions have over their own roles. The Department of Health should be aware that their policies and initiatives may be treated with mistrust and fear, and that future changes need the support of the staff who may implement them.

A conflict with medicine was revealed that appears to have occurred due to stereotypical views, poor communication and a perceived power imbalance that could affect the future of this closer working between medicine and podiatry and physiotherapy. Interprofessional education was also initially perceived as another government policy that had no justification or support from the participants. Further discussion revealed that the benefits could be in preparing students to be effective team workers.

Research to establish the effectiveness of this closer working in improving patient care and further research into podiatrist and physiotherapist roles within musculoskeletal teams is needed as this is a small study and may not be representative of the larger population.

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