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Professional differences in interprofessional working

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ABSTRACT

UK government policy is encouraging healthcare staff to blur traditional roles, in the drive to increase joint working between practitioners. However there is currently a lack of clarity regarding the impact that changes to traditional working practice might have on staff delivering the services, or on patient care. In this article, we report findings from three qualitative case studies examining joint working practice in stroke care, in which the influence of professional differences was a subsidiary theme. We draw on findings from individual semi-structured interviews, as well as fieldwork observations, to describe the influence of professional knowledge and skills, role and identity, and power and status considerations in interprofessional working. The insights that were gained contribute to the understanding of how professional differences impact on healthcare staff joint working, and suggest that the elements identified need to be fully considered in drives towards changed working practice.

Keywords: interprofessional working; professional; case study; stroke

Word Count: 4958

In the UK the call for change to healthcare service delivery has become a resounding one over the last few years, with attention being paid to the way that healthcare staff are trained, employed, developed by further training, and work together. These changes have been driven by an explosion of policy documents (Department of Health, 2000a, DOH, 2000b, DOH, 2000c, DOH, 2004) as part of a ten-year process of reform of the National Health Service. Leathard (2003, p.30) describes these policy documents as leading to an "avalanche of change" in healthcare staff working practice.

Throughout the history of the National Health Service, the professions and elements of professionalism have played a central role in service delivery. It has been noted that a major distinction between joint working practice in healthcare and in other contexts such as business and industry, is that workers in healthcare have professional groupings and different allegiances (Firth-Cozens, 2001). Professional organisations were developed to support practitioners in enhancing standards of care and in policing standards of their colleagues, a process that Saks (2000) describes as "social closure", where legally underwritten self-regulation of the professions excluded the unqualified, and gave power and status to the qualified.

Traditionally, definitions of professional practice have emphasised the key aspects as being: a high degree of expertise; the freedom to control the management of the task; a system of ethics; professional standards; and autonomy and dominance over other groups (Southon and Braithwaite, 2000). Hugman (1991) emphasised the "social power" that professionals possess, with claims to a particular knowledge base marking each one apart. As the primary means of distinguishing one profession from

another, professional knowledge is a key concept in healthcare working practice. Hall (2005) for example highlights differences in the way that individual professions construe and use professional knowledge. He describes clinicians "looking at the same thing and not seeing the same thing", as a result of possessing profession-specific "cognitive maps" which determine the framework for their clinical decision-making.

Medicine is the most established, and still dominant of the healthcare professions (Page and Meerabeau, 2004, Hafferty and Light, 1995). In the context of this medical dominance, other professions such as nursing and the therapy professions (Physiotherapy, Speech and Language Therapy, Occupational Therapy) have faced challenges in establishing position and status (Saks, 2000). Historically there has been "an acute power gradient" between doctors and nurses, with a well-documented professional hierarchy (Page and Meerabeau, 2004).

Interprofessional working clearly presents considerable challenges to practices dominated by power and status considerations. Professional differences have been described as "tribalism" (Beattie, 1995), developed as a result of professions evolving separately, with deeply rooted boundaries between them. These differences may also be a result of different training and philosophical approaches underpinning the professions (Fitzsimmons and White, 1997). Practitioners traditionally have been trained to function both independently and autonomously within professional groupings, and also have adopted the values, norms and stereotypes held by members of their particular profession as part of a process of professional socialisation (Mann et al., 2005, Howkins and Ewan, 1999, Fitzpatrick et al., 1996).

With the advent of changing healthcare delivery, authors have emphasised the need for new understandings of professional practice. Higgs and Jones (2000 p.4) for example propose a new model called the "interactional professional", redefining professional autonomy as "independence in function……..combined with responsibility and accountability for one's actions". Similarly, Hafferty and Light (1995) discuss the possibility of "reprofessionalisation" as individuals shift their identity and commitments from their profession to the organisation that they work in. In a discussion of professional perspectives on working together, Hubbard and Themessl-Huber (2005) highlight that that joint working is not just about transferring information, but about creating new thinking. They argue that there is a need to focus attention on "how knowledge is created rather than upon how knowledge is exchanged". Authors such as Jeffery et al. (2005) have adopted the term "shared mental models" to refer to this creation of shared knowledge amongst different professionals working together, which has the potential to lead to changed practice.

As highlighted above, the policy changes are encouraging role blurring and role re-design amongst staff. The need for substantial change is raised by Humphris and Masterton (2000) who argue that health need and workforce requirements necessitate a "whole system approach" to role development, with the opportunity to let go of past constraints. They contend that the professions need to evolve, and "may become almost unrecognisable in the nature of their role and function". Other authors emphasise that a balance has to be found which respects individual profession expertise and responsibility, but which equally recognises interests and qualities shared with others (Biggs, 2000). It has been proposed that in changes to role and identity, there is a need for "domain mapping" to help workers understand their own

domain and that of others (Hornby and Atkins, 2000). It has also been highlighted that in a state of rapid change there is a danger of role confusion (Lahey and Currie, 2005), and also, there is the potential for “a sense of loss and insecurity” (Williams and Sibbald, 1999) in the healthcare professions.

PURPOSE

Our purpose in this article is to report findings from a qualitative multiple-case study, which explored the role of professional differences as a subsidiary theme in a study of joint working practice amongst staff providing care to stroke patients. We aim here to present the findings which describe aspects of interprofessional working relating to staff knowledge and skills, professional role and identity, and perceptions of power and status linked to professional groupings.

METHOD

The findings reported are from in-depth case studies of joint working practice at three sites providing care to stroke patients. We used purposive sampling to select examples of practice across a typical stroke care pathway of hospital ward, specialist stroke unit, and community stroke team. The studies were located within a single region of the UK. Ethical approval was obtained via the NHS ethics procedure as a multi-site study, and research governance procedures for each organisation were adhered to.

Data were collected via several sources. In particular for the findings reported here, we used semi-structured interviews with staff of approximately thirty minutes duration, together with periods of fieldwork observation. The interviews were carried out by the first author, tape-recorded and later transcribed. The topics for the

interview were drawn from the literature on joint working, and were developed following three pilot study interviews. Although a topic guide (Berg, 1998) was prepared, the semi-structured nature of the interview also allowed the opportunity to explore and gain further insights into the data generated from the parallel fieldwork observations. The interview topics included: organisational conditions; goal setting; conflict and problem-solving; group process and team roles; professional roles and identity; beliefs about teamworking; patient involvement in care; and communication systems. A total of 37 interviews with staff were carried out, with representation from the range of professions providing care for stroke patients, encompassing: nursing; medicine; physiotherapy; occupational therapy; speech and language therapy; dietetics; clinical psychology; and assistants.

In order to gain insight into the context at first hand, we used an observation method in conjunction with the individual interviews. Observational methods may be of several types, with a continuum of participation at one end to observation at the other (Bechofer and Patterson, 2000), depending on the role of the researcher. For this study a non-participant observer role was adopted, with the first author carrying out the observations in parallel to the interviews. During the field work, data were collected via field notes, which documented observations, conversations, feelings and interpretations (Roper and Shapiro, 2000). Periods for observation were selected to give representation across a working week when more than one profession was present totalling 110 hours of observation, with study periods at the three sites of 30 days, 19 days and 26 days duration. Data gathering was concluded at a study site when we believed that saturation was reached and that new material was only adding

bulk to the data (Glaser and Strauss, 1967). In total we analysed 68 documents, consisting of 30 field note transcripts, 37 interviews transcripts, and a research diary.

Data management and analysis

The QSR NVIVO software was used to facilitate storage and retrieval of the data. The transcripts were stored as individual documents, and each document was read on a line-by-line basis and coded. A start framework (Miles and Huberman, 1994) of codes derived from the literature on joint working and the pilot interviews had been prepared, however this start framework was continually revised and expanded in an iterative process, as the coding proceeded. Coding was carried out in parallel to data gathering, with revisiting of all coding at the conclusion of each case study before commencing the next, and at the conclusion of the data gathering. Emerging findings were discussed with and reviewed by the second author, and also in a process similar to respondent validation, emerging concepts were discussed with participants during the fieldwork, and interviews.

FINDINGS

Following analysis of the data we uncovered three aspects of professional differences which are significant in joint working: (1) knowledge and skills, (2) professional role and identity, and (3) power and status.

Knowledge and skills

The "knowledge and skills" code was the fourth most frequently occurring code in the entire data set, occurring in 134 passages across 39 different documents. The data highlights the significance of depth of knowledge, with the perception of staff being

that the difference between professions was linked to the level or depth of specialist knowledge and skills, for example:

> "You need the background knowledge to be doing what you're doing effectively....I think...I think it probably does come down to effectiveness...I mean anybody can go and sit...with a patient and do some language stimulation but not everybody knows why they're doing it in which case...they might not be quite on the right track." (Document 'individual interview').

> "I think you can do up to a certain level and I think that assistants are a good example, that yeah it works at a level, but you cannot dilute that depth of knowledge." (Document 'individual interview').

The linking of individual professions with having greater depth of knowledge and skills raises the question of how junior staff functioned within the teams. Elements of the data relating to this area were gathered under a code called "how long qualified", with 49 paragraphs coded across 21 documents. Within this code an element that was highlighted by staff was the importance of seeking guidance from senior colleagues, for example:

> "I think when you are newly qualified you um you link to someone more experienced, and sort of follow them really." (Document 'individual interview').

Staff also described how their joint working practice had changed as they had gained experience, for example:

> "I think the development of it comes alongside so many other things as well. You've got to be grounded in your actual discipline first I suppose in order to be able to contribute in a team." (Document 'individual interview').

> "So...when you first qualify that's what's on your mind...what's my plan what am I doing with this patient....you tend to think of yourself more...but then...the more experienced you get..you're more comfortable with what you're doing physio wise and you think a bit wider...oh I need to speak to so and so about this...I need to refer on about that.." (Document 'individual interview').

Professional role and identity

Professional knowledge was presented above in relation to professions being distinguished by different depth of knowledge. There was also some data that

represents an alternative view, that it is the type of knowledge and skills that determine the role and identity of each profession rather than the depth.

For example, data describing nursing practice identified the nurse role as having primacy in two knowledge and skill areas. Firstly, the role of the nurse as provider of personal and basic needs care, and secondly the nurse role as relating to medicines and medical needs. Data coded to "nurse role" is the most frequently occurring of the data describing professional roles, being present in 110 passages across 37 documents, for example:

> "I think it's that they think you're a nurse so you're things medical and pressure area care and things like that as opposed to rehab the actual rehab." (Document 'individual interview').
>
> "Nurses would talk more about medication and continence and things." (Document 'individual interview').

Staff referred to nursing as being in a unique co-ordinating role, which was different to that of other professions:

> "I almost feel that nursing are the main bit in the middle as they have the fewest links out...they don't have a main department.....they tend to be the ones right in the middle of everything...that are there all the time.." (Document 'individual interview ').
>
> "We pull everything together we're the ones in the middle." (Document 'individual interview').

The physiotherapists were seen as a key staff group at the locations studied, having a clearly defined area of professional role and responsibility:

> "It's usually the physios who do an assessment....you know as to the moving and handling." (Document 'individual interview').
>
> "The main people I thought were the physios...." (Document 'individual interview').

There are 80 passages coded across 31 documents for “doctor role” in the data, second only in number to “nursing role”. This is surprising considering that at two of the sites patients were required to be medically stable to be transferred there, and that one of these sites had no doctor as part of the team. The doctor role seemed to be clearly defined amongst the staff, particularly in terms of decision-making, for example:

> “Yes we sometimes will look at the consultant as having to do the doctor bit..” (Document 'individual interview').

> “Nurses emphasising need for medical confirmation of discharge for patients indicated, and other team members also using medic as discharge tool, and using medic as authority figure to give emphasis to information or decisions made e.g. talking to a difficult relative.” (Document 'field notes’).

Other professions at the sites included speech and language therapy, dietetics and clinical psychology. These professions seemed to have defined roles by nature of area of expertise, for example:

> “Team leader asked what SLT recommending that other team members who were going to work with him should do in regard to his talking, and asked for specific things - SLT responded by giving specific advice”. (Document 'field notes').

However, by virtue of them not having a full time presence at the location, elements of their role could be taken on by other staff, for example:

> “No SLT present, medic asked nurse for each patient whether they were swallowing all right and nurse gave information.” (Document 'field notes').

> “When I go and see them think oh... are they on thickened fluids, or oh... how are they swallowing so I can feed back to the SLT cos they’re not going to be there all the time.” (Document 'individual interview ').

The occupational therapy role seemed the least well defined role, and could vary between sites:

> “It’s well who co-ordinates the whole package who’s really there to sort it all out to make sure they go home with everything that they need..and that to me feels a bit hit and miss...kind of ..often the OT picks that up.” (Document 'individual interview ').

> “The OT is going to know most about perception and cognition...although now we’ve got more psychology input that’s going to be an interesting more of a merger that will develop.” (Document 'individual interview ').

The data indicated evidence of a blurring of boundaries in particular between the occupational therapy and physiotherapy professions, particularly amongst more senior staff, and some evidence of nursing taking on a role that encompassed elements of all the therapy professions, for example:

> “Here it has at times gone the other way...in that actually boundaries are getting slightly blurred.....um...because the home visit for example is an area which is predominantly the OT...area and it’s for us to set it up for us to decide who goes...and it gets very much on here like it’s a joint thing with the OT and physio.” (Document 'individual interview ').

> “Discussed the nurse role in acute settings as the co-ordinator of services around the patient, she agreed that that was often the role in acute settings and that she had a similar co-ordinating role in community.” (Document 'field notes').

As mentioned above, some staff linked any blurring of roles to availability of colleagues, with staff either based full time at a location and or others having a part-time presence or limited time availability, for example:

> “I mean that’s very much blurring of roles..cos we’re not here at night.” (Document 'individual interview ').

> “A little bit, I would say there is role blurring on here.. I think when it’s necessary there is.. if people are around.. then you don’t necessarily need to have to although.. you do try and engage other people in trying to help you make that decision even though it’s not necessarily their role... I think if you’re the one that’s there, if you are the one doing something with them, and it naturally imposes upon you to do aspects” (Document 'individual interview').

In contrast to this perceived reduction in defined roles associated with availability of staff, the data also provided evidence of role clarity amongst staff and clear boundaries between professional groups, often linked to the depth of professional knowledge, described above. In the data 143 passages (the third most frequently

occurring code) are coded to “role and identity – know boundaries”, with staff reporting that professional role boundaries remained clear, for example:

> “I know what my job is...and I know what other peoples job is...I think... I don’t overstep the boundaries and I don’t think they do either.” (Document 'individual interview').

> “What marks each profession apart is actually...everybody has got this genericy surface bit but that once you get....into this real depth of competence...that’s almost where you have got the boundaries....” (Document 'individual interview').

> “Well obviously it’s profession led...cos physio and OT are not always the same.....yeah...cos they’re two different professions you see...but they all look for the same thing....and you know...they all talk…but you know physios obviously….see physio side...OT...OT side and so on....”(Document 'individual interview').

During the interviews professional identity was explored by asking participants where they felt their loyalties lay, to the team or to their profession. Staff frequently referred to themselves and their colleagues as being “the team” in discussions, however, in contrast to this espoused team membership, it is interesting to note that there was variation amongst staff as to whether they saw their identity as a team member or as a member of their profession. Some staff linked their perceived identity as a team member to feelings of closeness achieved by regular contact and smaller staff numbers, for example:

> “I do see myself as part of the physio department....but um..I probably feel my loyalty is more to the stroke unit than the physio department as a whole because it is too big....” Document 'individual interview'.

> “I would say probably slightly a larger percentage to the team...than to the OT service cos I am based here and these are the people that I work with every day....but um...yeah I am still sort of....” Document 'individual interview').

However, professional identities remained strong, in particular relating to notions of duty of care, and everyday patient treatment:

> “Primarily I am a physiotherapist and my responsibilities are to the patient.” (Document 'individual interview').

> "I refer back to the OT team a lot..my colleagues...for support and where am I going with this patient...and..clinical knowledge". (Document 'individual interview').

Power and status

The data that was coded to power and status was often also classified within two other codes, with links being made to the medical role, and also to decision making. The influence of power and status in the study sites seemed therefore to relate to the role of the doctor and especially related to decision-making. References to power and status in relation to the profession of medicine include, for example:

> "Written in notes by consultant. Decisions re discharge seem to be taken solely by the consultant, one occasion when he seemed to have put back discharge date, only staff nurse knew about it, no-one else." (Document 'field notes').

> "There has to be a discharge form which the medics have to sign." (Document 'individual interview').

> "The doctor will be saying, are we getting anywhere do we need to go, you know we should be getting them moved on." (Document 'individual interview').

However, in contrast to this, there was evidence of some staff perceiving there to be an erosion of these traditional assumptions:

> "I don't see a consultant being at the top of the tree... because I see that 99% of the time we can manage without one." (Document 'individual interview').

> "It should be a circle with everybody in it..I don't think it should be ...a hierarchy ...a sort of pyramid with the consultant at the top....the rest of us at the bottom...I think that's wrong...cos...I think that yes the consultant is the highly paid highly qualified um..professional..but they have quite a limited role.." (Document 'individual interview').

Also, it was reported that the particular context of stroke care impacted on traditional power and status assumptions. Staff linked this to a transition from a more "medical model" view of care in acute medicine, to the more "rehabilitative model" needed in stroke care:

> “Sometimes in a medical model their way of working is the one to go with... however in a team like this when it’s rehabilitation…the medical model isn’t the right model to take...” (Document 'individual interview').

> “Because it’s rehab orientated that we get more recognition from the medical staff....on a rehab ward than we would do on an acute ward” (Document 'individual interview').

DISCUSSION

Our purpose in this article was to describe professional differences in interprofessional working. We have identified three significant features of professional groupings, these being (1) knowledge and skills, (2) professional role and identify, and (3) power and status.

The findings have highlighted the central importance of professional knowledge in understanding working relationships between healthcare staff. The data describes the exchange of knowledge and skills at the study sites, which seems to be at variance with traditional notions of professional practice where individual professions have discrete areas of knowledge and skills. Authors such as D’Amour and Oandson (2005) propose that knowledge exchange will result in the reforming of professional boundaries. The data from this study provides some support for this, presenting evidence that there was considerable knowledge transfer between professionals at the locations investigated. The study participants believed there to be some blurring of boundaries, for example highlighting the nursing role as taking on knowledge and skills from the therapy professions and acting as a central focus for joint working. There was also some evidence in the data of knowledge and skills exchange being needed, when other professions were not available to provide input.

However, whilst describing the exchange of knowledge and skills we argue that the study in fact found little evidence of role boundary blurring, with the data identifying clear areas of role clarity and primacy for each professional group, with role clarity being apparent in observed and reported practice at the sites, and with role distinctions being linked to depth of knowledge.

The literature on professional knowledge would suggest that the preservation of professional boundaries linked to depth of knowledge is explained by the complex nature of professional practice as being more than a collection of knowledge and skills (or competencies). Fish and Coles (2000) describe the "professional artistry", Schön (1983) the "grey areas of practice", and Hall (2005) the "cognitive map" unique to each professional achieved by practitioners as they gain experience and become "expert" (Dreyfus and Dreyfus, 1986).

We contend that the findings indicate transfer of knowledge and skills between different professions, but without this exchange leading to blurring of role boundaries. We suggest that for blurring of boundaries to take place between professions there needs to be an understanding of another profession's tacit knowledge (Rogers, 2004), complex clinical reasoning (Boshuizen and Schmidt, 2000, Higgs and Jones, 2000), and enculturation (Bromme and Tillema, 1995) which may only be achieved by expert (experienced) practitioners. At the sites studied here, the blurring of role boundaries was predominantly between the occupational therapy and physiotherapy senior staff, which it could be argued being both allied health professions may have similar clinical reasoning and enculturation.

In regard to professional identity, there was variation amongst staff whether they saw themselves firstly as a member of their particular profession, or predominantly as a team member at that site. Staff described how their joint working practice had changed over the years as they gained depth of knowledge and skills, declaring the need to firstly become established in their own profession before operating as a complete team member.

The literature highlights that self identity may be best known through others (Pellatt, 2005), thus fellow team member's perceptions will have a significant impact on an individual's sense of their own identity. It is therefore suggested that professional identity and changing identity in a team context may be complex. The importance of the preservation or erosion of professional identity has been highlighted by other studies (Davoli and Fine, 2004, Williams and Sibbald, 1999), suggesting that the linking of role and identity to professional knowledge and skills described here needs further exploration.

Another aspect of professional differences that the literature highlighted is the element of power and status. In the data this element was most closely associated with decision-making and the medical role, seeming to suggest that changed healthcare practice to date has had little impact on changing power and status assumptions. Colyer (1999) argued that "the leadership presently vested in medical practitioners must change" if joint working is to be a reality. Similarly, Kennedy (2006) emphasised that professionals must be encouraged to redefine their professionalism in order to change power differentials. In a discussion of Co-operation Theory and Social Exchange Theory, Loxley (1997 p.39) emphasises the need for parties to have

equal powers if joint working is “not to degenerate into coercion”, and the need for recognition of perceived benefit to all participants through joint working.

It is important to note that the perception amongst participants was that the sites were operating in a mostly non-hierarchical system, even though the medical profession dominated interactions during team meetings at two of the sites. These meetings were the decision ratification forum, and medicine had the role of decision-maker in terms of the process of patient care (i.e. referrals on to other agencies, further testing, discharge) and medication. At the hospital-based sites patients were admitted “under the care of the consultant”, thus preserving this ultimate decision-making role.

However, although the data describes the power of the medical staff in relation to decision-making, it seemed that this was a perception that was perpetuated by all, but which was not always the reality with non-medical staff sometimes reaching consensus amongst themselves, and able to influence decision-making by this association. On these occasions it seemed that the status of medicine was preserved but not necessarily the decision-making power. This echoes Payne (2000 p.142) who reported that “power is a matter of perception not actuality”. However, applying a Social Exchange Theory view or a Co-operation Theory view of joint working (see Loxley, 1997), even where there may be some sharing of the power of decision-making via joint working, it is hard to identify a circumstance where medicine could be seen to benefit from erosion of its’ status.

The findings regarding the influence of context and healthcare model on power and status assumptions are of significance in this discussion. The client care pathway of

patients who have had strokes is that of decreasing involvement of medicine as care moves from acute to rehabilitation in the community. In the community context there seemed to be a “status equal” position, which may have been associated with little or no medical involvement, a finding supported by Hugman (2003) and Colyer (1999). Also, it seemed that as care became less acute and “medical model” orientated, that medicines’ dominant position was eroded.

CONCLUSIONS

Qualitative studies such as this are helpful methods for developing greater understanding of complex phenomenon, such as joint working practice. The qualitative methods used in this work have been able to generate large volumes of data in order to build explanations, a cornerstone of arguments for employing a qualitative methodology. They have also been able to gain an understanding of practice in the field, and have been able to shed further light on detailed elements, and interrelationships between elements, which can be seen as a further strength of this methodology.

The influence of professional differences has emerged as an important factor within interprofessional working. The findings highlight that the significant elements of professional groupings in interprofessional practice are: knowledge and skills; professional role and identity; and power and status. We suggest that the influence of these needs to be fully considered in understanding and implementing healthcare joint working practice. Further work is needed in particular to investigate the area of professional knowledge acquisition and exchange in joint working. In this article we

have argued that professional knowledge and knowledge transfer is a key aspect linked to role boundaries, role blurring, and professional identity.

The importance of context and model of healthcare raises the possibility that issues of professional differences may vary between patient groups and working locations, and this needs further exploration. This research has investigated a small number of sites delivering services to a single patient care group, in one region of the UK. Other similar studies investigating the complex phenomenon of professional differences are needed, if the impact of current changes to healthcare working practice is to be fully understood.

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