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An exploration of collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting

Melissa Williams Owens

A thesis submitted to the University of Huddersfield in partial fulfillment of the requirements for the degree of Doctor of Education

The University of Huddersfield

November 2014

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Abstract

This study critically explores how Bourdieu's (1985; 1989) concept of social space impacts on the experiences of medical and nursing students in the primary care setting when non-formal work based learning (WBL) is used as a model for interprofessional education (IPE) (Moore, 2012). Current ways in which professionals conduct their relationships with each other are also examined and factors that impede collaboration are also explored using Bourdieu's theory of social life (1979; 1985; 1989; 1992; 1996; Bourdieu & Wacquant, 1992) as a theoretical lens.

Bourdieu (1979) uses the concept of social space as a means of exploring power and hierarchical relationships arguing that social space influences relationships so that whilst groups of people can be located in the same physical space, they can remain socially distant (Bourdieu & Wacquant, 1992). In the United Kingdom (UK) different professions are now located together, within GP (General Practitioner) Practices, in the belief that it will enhance CP (DH, 2005; Hudson, 2007). However, there are a number of factors influencing how doctors and nurses work together and these include the powerful position of the doctor in relation to the nurse (for example: Coombs & Ersser, 2004; Davis, 2003; Fagin & Gaerlick, 2004, Malloy et al 2009, Vogwill & Reeves 2008). Therefore, students placed in this environment are likely to be immersed into practices where power relationships occur and supervised by those who are involved in them. As such it is likely that they learn the implicit, hierarchically influenced, rules of engagement that are practiced by their qualified counterparts (Collin et al., 2011).

The study drew on critical ethnographic principles and took place in a city in the north of England. Participants were selected purposively and were comprised of the staff from three GP Practices, as well as medical and nursing students who were on or had recently completed a clinical placement at one of the three Practices. Data were collected predominantly through uni-professional focus groups alongside a selection of observations. Field notes were made at the time of the observations and a reflexive diary kept throughout. I transcribed the focus groups verbatim and uploaded them into NVIVO8 with analysis undertaken using template analysis (King, 2004).

Whilst CP is now accepted as a fundamental part of contemporary health care (Barr et al., 2005; Dickinson & Sullivan, 2014) there is little clarity regarding either its meaning (Haddara & Lingard, 2013; Lingard et al., 2012) or of how it should be achieved (King et al., 2013) and could be the reason that measurements of its effectiveness are limited (Barr et al., 2005; Zwarenstein & Reeves, 2006). Exploration of CP within an emancipatory discourse

however suggests a multitude of interplaying influences on how professions engage (Ansari et al. 2001; Haddara & Lingard, 2013). Indeed, findings from this study showed that whilst staff groups perceived CP to be positive, there remained a complex interplay of factors that impacted on how it occurred. In particular the dominant position of the doctor remained problematic influencing how, when and if it occurred. Physical space, elusiveness, communication methods, titles, language and tasks performed were all found to be significant in relation to the level and type of capital held and therefore the social space between professions. However, these were frequently masked by the physical space and distance between the staff groups.

Bourdieu (1985; 1986) argues that the habitus of the individual is also influential in relation to social relationships as it is an inherent element of who a person is: influencing how they think as well as what they say and how they say it. The individuals' habitus will ultimately manifest itself as a set of 'tastes' which shape their identity (Bourdieu, 1979) and how they engage with their environment (Bourdieu & Wacquant, 1992). The socialization of students into uni-professional practices resulted in their becoming indoctrinated into the epistemological norms of the profession to which they aspired: adopting similar tastes to their qualified counterparts. In this way the official criteria of WBL became lost in the unofficial criteria of social compliance to the hierarchical position held by their qualified counterparts (Billet, 2001a). The conclusions from this study argue that collaboration is complex and that greater recognition is required of those factors that impact on it: and in particular the power imbalance between doctors and nurses. Equally, current assumptions regarding students' learning in this setting need also to recognize the complexities of CP, rather than simply relying on the experiences into which they are immersed to enable them to attain the goals of IPE and become 'collaborative practice ready' (WHO, 2010) at the point of qualification.

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I would like to acknowledge my supervisors Pete Sanderson and Nigel King for their continued support and belief in my ability to succeed

List of abbreviations

CP	Collaborative practice
DN	District nurse
DPM	Deputy practice manager
IPE	Interprofessional education
IPL	Interprofessional learning
GP	General practitioner
HV	Health visitor
MDT	Multidisciplinary team
NHS	National Health Service
NP	Nurse practitioner
PM	Practice manager
PN	Practice nurse

Introduction

The aim of this study is to critically analyze the processes and conclusions reached when attempting to explore collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting.

At the outset, three questions were identified in order to support these aims being achieved as follows:

- How do participants from varying professional backgrounds (principally doctors and nurses) experience their relationships with others in primary care?
- What factors (such as status and organizational infrastructures) impact on the way in which doctors and nurses collaborate in the primary care setting?
- What factors impact on the use of non-formal interprofessional education with medical and nursing students in the primary care setting?

There is an expectation that medical and nursing staff will work together, collaboratively, in order to provide a seamless service to its patients within a health service that has been recognized as fragmented (Department of Health [DH] 1998; 2010b; World Health Organisation [WHO], 2010). Evidence of this emanates from the continuing, grand-scale, failings in achieving effective CP including high-profile tragedies such as the death of Victoria Climbié (Laming, 2003) and of a sustained high mortality rate of infants undergoing coronary heart surgery at the Bristol Royal Infirmary, despite continued concerns being raised as to their success rates (Kennedy, 2001). The subsequent Inquiries from these deaths identified in their conclusions poor or inadequate communication between professions with regards to the Laming Report (2003) and of doctors having too much power with too little accountability in the Bristol Inquiry (Kennedy, 2001). Attempts have been made to address these issues at national level through the restructuring of the National Health Service (NHS) by altering and extending staffs' roles and by the introduction of shared learning between health and medical staff (DH, 2000). Despite this there appears not to have been any reduction in the level of child abuse cases reported to date (Dickinson & Sullivan, 2014) and evidence of continued, endemic, neglect of patients remains (Berwick Report, 2013).

There remains, also, a lack of clarity in the theoretical literature as to both the meaning of CP and as to how it should take place (Dickinson & Sullivan, 2014; Haddara & Lingard, 2013). A wide variety of differing terms are used to define CP, for example (Ansari et

al., 2001) alongside differing criteria as to how it should take place (King et al., 2013). This makes taking a functionalist approach to evaluation problematic and indeed evaluations as to its effectiveness using this approach are ambiguous (Haddara & Lingard, 2013). Taking an emancipatory approach, however, enables exploration of factors that can impact on CP processes, rather than outcomes (Haddara & Lingard, 2013), examining both contemporary and historical influences.

In the primary care setting, in particular, the challenges faced by professionals to work collaboratively appear to be particularly complex. For example, 90% of health care takes place in this setting (DH, 2005) where patients' needs can be both multifaceted and diverse (Brown & Wells 2011; DH, 2005). In addition, there are a large number of professions and agencies potentially involved in the delivery of health care (DH, 2005; Parrott, 2005). The National Health Service and Community Care Act (1990), for example, attempted to provide increased flexibility and choice of care provision which saw a significant growth of potential agencies involved in primary health care provision to include those from the private and voluntary sector. This created a greater complexity with regards to working collaboratively in this setting, with no recognition or guidance at that time, as to how this should be achieved (Parrott, 2005). Attempts were later made to address this in the belief that CP could be improved by locating different professions within the same physical space (DH, 2005; Hudson, 2007). As a result the organization of primary care saw a major change with GP Practices expanding and different health (and often) social care professionals moving in order to be physically located under the one roof (DH, 2005; Hudson, 2007)

Whilst there are now a wide variety of providers involved in health care in the community, the doctor and nurse remain the key players (Reeves et al., 2008) and, as I will argue in chapter one, the numerous challenges to their working collaboratively are well documented. As early as 1967, for example, Stein (1967) described the complex, power-related relationship between doctors and nurses and the 'games' each played in order to maintain their position in this hierarchical relationship. Despite this, there is an expectation that pre-registration medical and nursing students will become equipped with the knowledge and skills in order to work collaboratively (WHO, 2010; Barr et al., 2011). However, due to the complexities of health care provision in the primary care setting described above (DH, 2005; Parrott, 2005), the ability to achieve this appears particularly challenging (for example: Dearnley et al., 2010; Nyatanga 2005, Owens & Dearnley 2011, Piertroni, 1991) and forms the over-riding rationale for my study. For example, the pedagogical ideology of 'interprofessional education' (IPE) has been introduced as a means of teaching pre-registration health care students CP skills (Barr, 2002, Barr et al., 2011). The delivery of IPE, however, remains particularly complex (for example: Barr et al., 2014; Dearnley et al., 2010; Freeth et al.,

2001; Freeth et al., 2005; Hughes., 2014, Kamin et al., 2006; Zwarenstein et al., 1999) with limited evidence of its effectiveness (Hammick et al., 2007) and a lack of theoretical underpinnings to support its delivery (Barr et al., 2005; Hammick et al., 2007; Huchings et al., 2013). Within the primary care setting the problems appear to be even more challenging. Not only is CP more complex, but there are also specific issues with facilitating the acquisition of CP skills in this setting. One issue is that health care is provided over a wide geographical area, with numerous bases containing small numbers of professionals in comparison to the acute hospital setting (DH, 2005; Hudson, 2007) resulting in there being limited numbers of students dispersed across a wide geographical area. Evidence of this is supported by the lack of 'teacher-led' initiatives that are evident in this setting and an increased focus on work-based learning (WBL) initiatives (Barr et al., 2011). The use of WBL, however, has particular challenges in itself which call into question its ability to support students learning effective CP in this setting (For example: Barr et al., 2011; Billett, 2001a; Billett, 2001b; Billett, 2004; D'all Alba, 2009; Kinsella, 2009; Williams, 2010; Yardley et al., 2012). I will discuss use of WBL and the difficulties faced in using it as a means for facilitating IPE in depth in chapter two.

Chapters one and two offer a 'back-drop' to this study, providing a review of the literature which supports the focus and rationale for this study. In **chapter one** I provide an overview of those factors influencing CP at a macro level. In particular, I discuss the lack of clarity with regards to definitions of CP and to the processes, therefore, in achieving it. I explore how differing discourses can influence how it is viewed and the influence of doctor's power on CP and in particular regarding the doctor-nurse relationship.

I also explore the doctor-nurse relationship and in particular what Stein (1967) and Stein et al. (1990) describe as the 'doctor-nurse game'. Using sociological concepts of professions and professional practice in particular, I explore the dominant relationship of the doctor in relation to the nurse and consider the historical factors that may influence this.

In **chapter two** I examine the relationship between CP and IPE and in particular provide a time-line of government initiatives introduced as a means to enhancing CP alongside the development of IPE. Whilst there is an agreed definition of IPE, there is a lack of clarity as to the meaning of CP, and therefore how IPE can enable it to be achieved. Focusing again on the processes however I discuss the existing difficulties evident in its delivery both within the university and the practice setting. In relation to practice I focus specifically on the challenges of implementing IPE in the primary care setting and the use of work based learning (WBL) as a model. In doing so I explore the influence of the different epistemologies on professional practice and in particular the effect of taken-for-granted behaviours on both what and how students learn. I also consider the ways in which these behaviours shape future professionals'

characteristics and the influence it potentially has on the doctor-nurse relationship. I also provide a brief introduction to Bourdieu's theory of social life (1979; Bourdieu & Wacquant, 1992) explaining how I will use this as a theoretical lens for examining 'what is happening' in the study in the context of what is already known.

The remainder of this thesis focuses specifically on the study itself. **Chapter three** describes the framework and methods I used. I present a description of the study and a more detailed account of Bourdieu's theory of social life (1979; 1985; 1989; 1992; 1996; Bourdieu & Wacquant, 1992) providing a rationale for its use and its relevance to this study. The field is also presented and I offer a justification as to the methods I used in order to gather the data. I also offer a rationale for my use of template analysis (King, 1998; 2004) which was used as a framework in order to frame my analysis of the data and facilitate my identifying the final themes.

Following this, the study findings are provided in two separate chapters (chapters four and five). In the first of the findings chapters (**chapter four**) the factors influencing CP in the field are identified including a discussion as to how the use of Bourdieu's theory of social life (1979; 1985; 1989; 1992; 1996; Bourdieu & Wacquant, 1992) helped explain what was happening. In particular the influence of social and physical space is discussed with examples given as to how and when it was used to influence CP.

Next in the second of the findings chapters (**chapter five**) I explore the impact of the field on the students' experiences and consider in particular how the findings from chapter four may have influenced these. Attention is given as to factors that appear to influence the students' learning experience and in particular the influence of the different epistemologies on this.

In the final chapter (**chapter six**), I draw together the significance of the findings and considered these in relation to what was already known in the literature and the overall aims of my study. I end with a discussion as to the strengths and limitations of this study itself.

Chapter One

Background to Study

As stated in the introduction the aim of this study is to critically analyze the processes and conclusions reached when attempting to explore collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting. In pursuing this aim, it is important to consider those factors that influence the effectiveness of CP and therefore the role of IPE in attempting to achieve this. The extensive literature on CP and IPE has become increasingly diverse in terms of theoretical positions which inform it, and the aim of this chapter is to set my study in the context not only of that strand which is concerned with identifying the constituents of 'effective practice' and measuring those interventions which endeavor to develop it, but also more recent perspectives which seek to place collaboration within a broader socio-material context. In addition I will draw on an older tradition of sociological work on the history of professions and professional practice, accepting that there are historical factors that appear to continue to influence professional practice and CP today. In particular I will explore recent works on medical hegemony and consider its impact on collaborative practice.

The recognition that health (and social) care professionals need to work together collaboratively in order to provide effective health care is now considered a fundamental element of health care delivery (Barr et al., 2005; Dickinson & Sullivan, 2014; King et al., 2013) with doctors and nurses considered to be the key players (Coombs & Ersser, 2004; Haddara & Lingard, 2013; Reeves et al., 2013; Reeves et al., 2008). Whilst much has been written regarding CP, there is a lack of clarity in the academic literature as to its theoretical meaning (Dickinson & Sullivan, 2014; King et al., 2013; Lingard et al., 2012; Reeves et al., 2011; Trojan et al., 2009). Despite this lack of clarity there remains a significant body of literature relating to CP which takes a functionalist approach and assumes an end result which generally refers to an improvement in service-user outcomes (Dickinson & Sullivan, 2014) and job satisfaction (Haddara & Lingard, 2013) which can only be demonstrated through positivistic research which is empirically tested and provides testable evidence (Haddara & Lingard, 2013). Evaluations and systematic reviews measuring its effectiveness in this way, however, are limited (Barr et al., 2005; Zwarenstein & Reeves, 2006) and when carried out are inconclusive and ambiguous in their findings (Haddara & Lingard, 2013; Hammick et al., 2007).

One reason for this inconclusiveness maybe due to the lack of consistency in the way in which CP is defined (Haddara & Lingard, 2013). Some, for example, focus on what it is not rather than what it is. Miller et al. (2008) argue that collaboration is not represented by the adoption of those linguistics preferred by the medical (dominant) profession nor yet by

remedying lack of reciprocity or equity in status. Equally Reeves et al. (2013) identify a professional distinctiveness evident within individual professions which serves to pull them apart rather than together. Others, such as Pullen (2008), identify barriers to its successful attainment: citing the complex interplay of (inter) professional relations as a significant influence on its not being achieved while King et al. (2013) highlight the fact that it is most commonly recognized when it is absent rather than it is present. Others still (for example: King et al., 2013; Zwarenstein & Reeves, 2006) emphasize the poor health care outcomes that can occur when it is not in place.

There appears also to be a plethora of terms used to describe CP which could affect the clarity of its meaning. These include: interprofessional working, collaborative working, team working and collaborative care (king et al., 2013), interprofessional practice (Clarke, 2011) as well as collaborative practice (D'Amour et al., 2005) and co-configuration (Warmington et al., 2004). In addition, others talk of an interprofessional, multiprofessional, interdisciplinary or transdisciplinary team (D'Amour et al., 2005; McCallin & Bamford, 2007), interdisciplinary collaboration (Reeves et al., 2011), inter-agency, multi-agency, inter-sector working (Warmington et al., 2004) as well as joint-working (Ansari et al., 2001). Partnership working is also used to describe working collaboratively although seems mostly to be used in relation to social care and third sector working (Lethard, 2003; Warmington et al., 2004) or patients (Marlowe et al., 2012).

The concept of CP also appears to alter depending on the setting in which it occurs. Within the acute hospital, for example, health care professionals are likely to be practicing synchronously within the same physical space and providing care which is more acute than in the primary care setting (Baker et al., 2011). Conversely CP that takes place with the primary care setting is likely to be more diverse and potentially complex in comparison to the acute hospital. For example 90% of health care takes place in the primary care setting (DH, 2005) where patients' needs can be both multifaceted and diverse (DH, 2005). In addition, there are a large number of professions and agencies potentially involved in the delivery of health care (DH, 2005; Parrott, 2005). Conversely the intensive care setting is equally suggested as being a challenging environment for CP due to the nature and intensity of CP as well as the close, physical, proximity of the staff (Lingard et al., 2012). Thus the meaning of CP is also likely to be influenced by the physical environment in which it takes place.

Despite this complexity of terms and settings, some have in fact attempted to define CP. However, there appears to be no singularly agreed meaning to what Barr et al. (2005) describe at the simplest level as 'working together' (p15). In terms of definitions I have found a number offered in the literature with varying degrees of complexity. Some focus

on the process: Kvarnstrom (2008), for example, describes it simply as team working. Others emphasize team working but suggest it also means shared attributes. Reeves et al. (2010), for example, argue that it requires its members to hold a shared identity. D'Amour et al. (2005) also concur with this definition. Similarly Pullen (2008) describes it as a mutual dependency and the working together on a common 'process' (p93). She argues, however, that this working together can be fluid. Alternative definitions emphasize both the process of collaboration as well as the intended outcome. Ansari et al. (2001), for example, suggest that the benefits should be greater than those achievable by an individual. King et al. (2013) go further still and describe it as the interactions of two or more health care professionals who come together in order to deliver appropriate care to a service user. Interactions, however, need not necessarily take place as part of a formal, on-going, team relationship but can be transient and indeed superficial (King et al., 2013). Whilst these definitions focus on the coming together of professionals, others identify the patient as the main focus and therefore argue that CP could mean working in parallel rather than jointly (Puonti, 2004). These conflicting definitions are likely to mean that evaluation of its effectiveness is likely to take place using different criteria, based on the different meanings attributed to it (Ansari et al., 2001).

Equally it is likely to mean a diverse understanding of how professionals can actively engage in CP: particularly if it is to include a disparate selection of individuals and groups with differing (and even opposing) levels of engagement as some of the definitions above suggest (Warmington et al., 2004). Despite this I found a number of attributes for positive CP described in the literature. These included attributes of people such as trustworthiness (Pullen, 2008), being good communicators (Bokhour, 2006) and being adaptive, knowledgeable and energized (Lingard et al., 2012) as well as making an effort to engage (D'Amour, 2005). Other attributes related to team processes such as: participation (Bokhour, 2006), knowledge sharing and joint responsibilities (Johnson & Kring, 2012). Others still describe attributes of the team including: a flat hierarchy (Johnson & Kring, 2012), shared power (Miller et al., 2008), shared values (Pullen, 2008), reciprocal, inter-dependent, relationships (D'Amour, 2005; Warmington et al., 2004), a non-competitive approach to care (San Martin-Rodriguez et al., 2005) and collective action (D'Amour et al., 2005).

Whatever definition of CP is used will still mean professionals working across agencies and boundaries (Leathard, 2003). However, most focus of CP is on the interpersonal relationships within the teams with limited studies exploring the influence of the organization or wider social policy issues on CP (Dickinson & Sullivan, 2014; San Martin Rodriguez, et al., 2005). It has been argued, for example, that there is a dearth of strategies in place at organizational level to facilitate CP occurring, and a failure to explicitly identify how it should

be achieved (Warmington, 2004). Despite evaluations of the effectiveness of CP taking place, therefore, it appears that there is a lack of focus on those factors that can affect CP taking place and therefore interprofessional relationships. It would seem, therefore, that there needs to be a greater focus on the processes of CP rather than the outcome.

Contemporary practice, for example, has seen a major emphasis on achieving targets, performance indicators and outcome measures (Dickinson & Sullivan, 2014). In relation to this it could be argued that the goal of CP is to achieve both effective and efficient practice (Dickinson & Sullivan, 2014). Despite this there appears to be a lack of collective ownership, strategically, as to how this should be achieved, or indeed of the need to understand the inhibiting factors (Warmington et al., 2004). It could be argued, for example, that social policy ignores the challenges of CP: focusing on the ideal rather than the reality and as such making them unworkable at grass-roots level (Dickinson & Sullivan, 2014; Fotaki, 2010). Instead there appears to be an assumption that simply having a shared focus will mean that CP will effectively take place (Warmington et al., 2004). However in reality there is a complex range of factors which impact on CP. It is therefore important to attempt to understand CP both in terms of how different professionals conduct their relationships with each other as well as considering the external influences on those relationships.

It is likely, as Ansari et al. (2001) suggest that the different meanings ascribed to CP will have influenced how it is conceptualized and therefore the value placed on the different aspects of it and the effectiveness of its outcomes. There is, for example, evidence of an alternative discourse to that of functionalism which aims to achieve an emancipatory goal. This discourse offers an alternative 'truth' arguing that the goal of CP is to reduce medical dominance and provide a non-hierarchical, level, professional field (Haddara & Lingard, 2013). Therefore, the discourse used will affect the questions asked as to if, how and (potentially) why (or why not), CP is effective (Ansari et al., 2001) and equally provide separate and possibly conflicting recommendations (Haddara & Lingard, 2013). The facts selected will depend on the perspective of the narrator (Fenwick, 2012). In considering CP from an emancipatory perspective it is important to recognize the influence that external factors bring to bear and in particular in relation to achieving the equal, non-hierarchical, status between members that some suggest are essential for CP to occur (D'Amour, 2005; Miller et al., 2008).

A significant external influence that is considered within an emancipatory discourse is that of the culture of different professions and the impact this has on how individuals enter into a collaborative relationship. In particular it is suggested that professionals will be socialized into a discipline-focused way of viewing their professional world (Nairn et al., 2012; Goldie, 2012) which will be made up of unique values, customs, attitudes and behaviours

which are reinforced by education and socialization into a particular profession (Hall, 2005; Owens & Dearnley, 2011). Working collaboratively, however, requires professionals to adopt a new vision which is in contrast to this (D'Amour et al., 2005; Wackerhausen, 2009). In considering the influence of culture in this way it is likely that it will inhibit professionals working collaboratively, as each develops their own strong, (uni) professional, identity (Owens & Dearnley, 2011). According to social identity theory, for example, being part of a group gives individuals a sense of belonging and enables them to make sense of their world by creating meaning in relation to it. Creating a distinct identity helps boost individuals' self-image and reinforces their desire to conform (Holt, 2008). This 'in group' identity influences how those within the group perceive themselves (i.e.: positively) and consequently, therefore, how they see others (the 'out group') who are generally negatively defined and perceived in relation to themselves (Nyatanga, 2005). Belenky et al.'s (1986) feminist 'ways of knowing' also argued that different experiences will influence how [women] perceive reality based on their position within the world. Applied to professional identity this has also been found to influence both how professionals view themselves and how they see themselves in relation to other professions (Owens & Dearnley, 2011).

The influence of professional culture also appears to create a complex set of inter-related factors that impact on power relationships between medicine and nursing and part of this appears to be bound up in the ways in which professions are defined, and therefore how professionals practice, in relation to these definitions (Baker et al., 2011). As I highlighted above, shared power and reciprocity are considered an essential aspect of CP when considered from an emancipatory discourse (D'Amour, 2005; Johnson & Kring, 2012; Miller et al., 2008; Pullen, 2008; San Martin-Rodriguez et al., 2005; Warmington et al., 2004). However, much has been written regarding the position of power held by doctors and the negative impact this has on the doctor-nurse relationship from a sociological perspective and in particular the argument that the central aim of professions is to maintain their own position of power and control over others: utilizing the labour of others to their own advantage (Witz, 1992). Considering the concept of power in this way Witz (1992) argues that entry criteria are put in place in order to restrict access and protect the boundaries of the profession and facilitate professions such as medicine maintaining its position of authority (Martimianakis et al., 2009; Reeves et al., 2010; Witz, 1992).

This ability to continue to define and defend a distinct body of work is described by some as 'boundary work' (Baker et al., 2011; Collin et al., 2011; Martimianikis et al., 2009; Witz, 1992). Described not as a static field of knowledge it is considered to be stable at the core but be movable and flexible at the edges, where overlap with other professions occurs (Kilpatrick et al., 2011). Boundary work has been used as a means of describing how

dominant groups use power in order to lay claim to particular resources and is often used to explain how the medical profession have been able to maintain a privileged position and in doing so dominate others (Witz, 1992). As care has become increasingly complex, for example, medicine has been able to justify a protection of what they see as their 'territory' due to the expert knowledge they argue can only be delivered by themselves in order to meet the complexity of care needs (Reeves et al., 2013). Thus boundaries to their work are protected through the creation of a restricted, expert, body of knowledge that relates specifically to medical practice and is equally exclusive in preventing access to it by others (Reeves et al., 2010). This is further enforced by professional bodies that enable professions to regulate their own practice, rather than it being overseen by others (Freidson, 1970).

However, giving one professional a position of dominance means that others will hold a position which is subordinate to it (Witz, 1992). For example one way of holding power is through an exclusivity of knowledge and skills. In controlling its own profession and exclusivity of knowledge, however, a profession can then control the work of others when there is a belief that there is an inter-dependency of work. Therefore if one profession controls its own services based on a discreet knowledge and skill set, then it follows they will be able to control the services of others if there is a belief that the work of others supports their own (Freidson, 1970).

Medicine is considered to be one of the oldest and for this reason the most dominant of the professions (Hafferty & Light, 1995; Martimianakis et al., 2009; Reeves et al 2013) and from the outset has been associated with holding power, authority and status (Freidson, 1970; Hafferty & Light, 1995). As one of the first professions medicine was able to secure a strong political voice and dominate other professions that came later (Reeves et al., 2010). Thus it could be argued that a differentiation of status and position between medicine and nursing was established prior even to the inception of nursing as a profession and is likely also to impact on the differential power relations between the two (Reeves et al., 2010).

The Doctor-Nurse Game

Thus there appears to be a complex interplay of external, historical, influences on the doctor-nurse relationship which have the ability to create conflict between them and make working collaboratively within a flat, non-hierarchical, team challenging (Pullen, 2008). Indeed, considering how the status of the doctor impacted on doctor-nurse relationships in 1967 Stein identified what he described as the 'doctor-nurse game' (Stein, 1967). Clear hierarchical demarcations, he argued, were evident between the two professions with subtle rules of engagement adopted which enabled the superior position of the doctor to be recognized but remain unchallenged. 'Good' nurses, he suggested, learned how to guide and

advise doctors without seeming to do so and therefore avoid conflict. These nurses were then valued and likely to do well in their profession. Conversely those that didn't learn, or stick to the rules of the 'game,' were considered unpopular and failed to progress in their profession or even left. Equally doctors that didn't recognize the subtle recommendations of the nurses were considered ineffective (Stein, 1967). Therefore, just as students learn from the role models and feedback from those in their own profession (Apker & Eggly, 2004; Goldie, 2012), they also receive feedback from others from different professions which reinforces their appreciation of the hierarchical position they hold and how they engage with others who hold a different position. The recognized powerful position of the doctor, as I suggested above, is not a new phenomenon and is suggested to be influenced by a number of inter-related factors (Baker et al., 2011). Medical hegemony has continued to attract scholarly interest over the years though recently it has been argued that it has experienced a gradual decline (Ellis, 1996) with the 1960's being seen as the 'golden-age' for medicine (Hafferty & Light, 1995). Consequently when Stein revisited the 'doctor-nurse' game in 1990 he found that the relationship between doctors and nurses had changed with a number of reasons for this identified. These included: a lowering of esteem of the medical profession in the public's eye; the increase in female doctors which altered the historical norm of the male doctor-female nurse gender balance; a shortage of nursing staff and; an elevation in the nurse's status through education (Stein et al., 1990). The most significant reason, he argued, however, was the increase in academic education and qualifications undertaken by nurses with a prediction that this would influence the 'game' still further as nurses achieved higher academic achievements (Stein et al., 1990). The changes Stein et al. (1990) identified related to the nurses' behaviour arguing that the demarcations between the two professions had become less explicit. Whilst the doctors continued to hold a higher social position, this was less identifiable as the nurses now openly questioned and challenged the decisions of the doctor.

Despite this the existence, and significance, of the doctor-nurse game continues to stimulate much debate with a number of factors suggested as influencing their relationship. In particular, it is argued that there remains a significant difference in status between the two professions (for example: Apker et al., 2005; Davies, 2003; Miller et al., 2008; Thylefors, 2011; Wanzar et al., 2009) with a number of reasons for this suggested which appear to relate to the continued influence of the culture of professional practice (Baker et al., 2011). One example of this appears to be the level of autonomy that doctors enjoy in relation to nurses, despite the increase in nurses' credentials, and influences how they interact with each other. Doctors, for example, are more likely to work autonomously and hold ultimate decision-making powers, giving them a higher status than others (Adamson et al., 1995). When interacting, nurses are more likely to approach doctors on an ad hoc basis for decision-making requests, but this does not happen the other way around (Farrell, 2001). Conversely, doctors will

approach nurses in order to delegate tasks: even when the tasks in question don't form part of the nurses' role (Baker et al., 2011).

Although the level of nurses' autonomy has actually increased over the years (Allen et al., 2008; Quinlan & Robertson, 2010) it appears to still not be on a par with that of doctors. For example, whilst both doctors and nurses are autonomous decision-makers nurses have a greater level of constraints on their ability to make decisions, leaving them feeling powerless in comparison to doctors. They have, however, become skilled in maneuvering information in order for the doctor to accept their suggestions (Fagin & Gaelick, 2004; Stein et al., 1990).

What is evident is that the authority of the doctor continues to have influence over the nurse in a way that is not reciprocated. Nurses' autonomous decision-making, for example, tends to relate to day-to-day decisions whereas the doctor continues to hold overall accountability (Fagin & Gaelick, 2004). Therefore whilst nurses have reported a perceived autonomy they still acknowledge a subordinate position in relation to the dominant medical profession which influenced how they engaged, ensuring that the influence of status and hierarchy remained (Miller et al, 2008; Quinlan & Robertson, 2010; Wanzar et al., 2009).

Doctors also continue to hold power over the work of nurses. Referrals for work, for example, mostly came through the doctor, meaning that they act as gatekeepers to the work of nurses (Coombs & Ersser, 2004). Where work is delegated the complexity of the patient's needs is often used as a means of identifying who should undertake it. Thus patients themselves become categorized with those presenting with the more complex problems, and therefore considered as more importance, being retained by doctors and the less complex, and therefore considered less important, by nurses. Thus patients' are categorized into a hierarchy of needs which reflect the hierarchical relationship of the doctor-nurse relationship (Charles-Jones et al., 2003).

In addition, where doctors and nurses work together, it appears that the doctor continues to take the lead (Apker & Eggly, 2004). One example of this is the ward round where doctors retain control of the process and the decisions that are made (Coombs & Ersser, 2004). Equally in multi-professional team meetings it is the doctor who is likely to have authority over the nurse (Thylefors, 2011). Not only is their level of communication likely to be greater than that of nurses (Thylefors, 2011) but the type of the communication they use is also likely to reflect their authoritative position: tending to be action-orientated and problem-solving, in contrast to the descriptive and narrative-information directed communication used by nurses (Baker et al., 2011; Miller et al., 2008; Vogwill & Reeves, 2008; Wanzar et al.,

2009). This has been found to influence nurses' confidence to speak out in these meetings (Thylefors, 2011). The resulting subordination has been recognized by nurses who considered it to be the distinction between their own role and that of the doctor (Snelgrove & Hughes, 2000) and has previously been suggested as a reason for job dissatisfaction in nurses (Wanzar et al., 2009) and a reason for disengagement (Miller et al., 2008).

Due to the authoritative-type figure of the doctor, their presence within an interprofessional team can play a major role in influencing the dynamics of that team in a way unseen in those from other professions (Baker et al., 2011). This maybe because doctors consider themselves to be the leaders: seeing themselves as the decision-makers of the team (Apker & Eggly, 2004; Baker et al., 2011). Whilst there is evidence to suggest that this reflects their professional socialization (Apker & Eggly, 2004; Baker et al., 2011) this appears to be further reinforced by their increasingly being required to take on managerial roles (Numerato et al., 2012). This blurring of the professional and managerial roles appears to further legitimize their power position and control in relation to others (Numerato et al., 2012; Snelgrove and Hughes, 2000). Thus doctors continue to hold both direct and indirect authority over the work of nurses (Miller et al., 2008).

A further influence on the doctor-nurse relationship appears to be the value that is placed on different types of knowledge with medical knowledge holding greater value in comparison to nursing knowledge (Baker et al., 2011; Miller et al., 2008). For example, hierarchies of evidence continue to value most evidence that has been derived from describable, testable, replicable means (Jones, 2004a; Jones, 2004b; Schön, 1984; NICE, 2004). This view of evidence appears to be derived from the positivistic philosophy upon which the epistemology of medical practice is based (Apker & Eggly, 2004; Martimianakis & Albert, 2013; Schön, 1984). In relation to practice, doctors have been found not to value nurses' knowledge unless it is based on a scientific (medical) knowledge of evidence, dismissing contributions if they were made using the 'art' rather than the 'science' of nursing knowledge. Nurses therefore have had to learn to provide evidence in a manner which was congruent with the norms and culture of medical practice (Coombs & Ersser, 2004; Miller et al., 2008). For example, Miller et al. (2008) found that doctors lost interest during ward rounds if nurses reported on the emotional aspect of the patient's needs. Equally in the intensive care setting, Coombs and Ersser (2004) found that doctors dismissed nurses' contributions unless it was based on a scientific (medical) knowledge base, resulting in nurses learning what they could contribute and how. Whilst it has received limited discussion in the academic literature, the emotional work of nurses is a fundamental and arguably intangible aspect of nursing knowledge which defines nursing (Miller et al., 2008; Waddington, 2005). However, whilst this is embraced within nursing circles, it appears to be rejected within

interprofessional (doctor-nursing) ones (Coombs & Ersser, 2004; San Martin-Rodriguez et al., 2005). In particular, doctors have been found to disengage when nurses attempt to discuss the emotional elements of patients' care: resulting in nurses' emotional and physical disengagement and job dissatisfaction (McCallin & Bamford, 2007; Miller et al., 2008).

One difference that has been suggested to have been found in nurses since Stein's (1967) seminal work is the confidence that nurses now have to challenge doctors in a way that was previously considered to be a 'bad' characteristic. Whilst there is some evidence of studies where this was also found to be the case (for example: Slengrove & Hughes, 2000), others report a continued inability, on the part of nurses, to challenge doctors (McAllin & Bamford, 2007; Thylefors, 2011). This appears to be particularly true in the arguably traditional space of the operating room whereby the senior position of the doctor appears not to be readily questioned by the nurses with whom they work. This has been found to be the case even when the safety of the patient is potentially being put at risk (McDonald et al., 2005), suggesting that there continues to be a 'them and us' even when doctors and nurses work together within a close interprofessional team (San Martin-Rodriguez et al., 2013).

This 'them and us' in the operating room appears to be grounded in the attitudes of the different professions towards the protocols in place for evidence based (medicine/nursing) practice. Whilst nurses tend to work closely within the confines of the regulations in place, surgeons have been found to flout them (Broom et al., 2009; McDonald et al., 2005). Thus whilst the culture of the professions appears to continue to influence the behaviour of doctors and nurses, the field in which they engage will also impact on how CP occurs.

In addition, whilst nurses continue to extend their roles and undertake additional academic qualifications, it would appear that the significance of this is interpreted differently by the different professions. Snelgrove and Hughes (2000) in their study, for example, found that nurses believed they were able to play a more active role in the decision making process due to their increased level of assertiveness towards doctors. Doctors however, believed that nurses had increased their clinical expertise and as such valued and respected their contribution to the clinical decision-making process. However, these changes are perceived differently by the two professions. For nurses it is considered as a means to empowerment in the same way that women have been seeking equality through the civil rights movement. Through improved education, therefore, they were redefining themselves and moving away from the previous image of the nurse as handmaiden (Reeves et al., 2010; Stein et al., 1990). What they have not achieved, as I highlighted above however, is nursing autonomy: nurses are still unable to be the ultimate decision-makers regarding their patients, in the same way as their medical counterparts (Malloy et al., 2009).

One reason why orthodox medicine holds such power and influence in contemporary society, for example, is suggested to be because it legitimized its position through housing itself within the university (Jones, 2004a; 2004b). The move of pre-registration nursing into the university setting appears also to have taken place as a means of establishing legitimacy and increase the professional status of nursing (Deans et al., 2003) and improve skills in critical thinking (Morrall & Goodman, 2013). Since this time, nursing has continued to increase the level of academic qualifications that can be achieved with pre-registration nursing now being at an all-graduate level (NMC, 2010).

Despite this the type of knowledge upon which nursing is based remains less valued than that of medicine (Eisner, 2002). Medicine continues to be based on a science of knowledge that either generates theory or is governed by it (Schön, 1984). Nursing, however, is based on an artistry of knowledge which is governed by a complexity of rules that require an emotional engagement and interpretation of theory rather than a testing of it (Eisner, 2002; Miller et al., 2008; Waddington, 2005). This attempt by nursing to attain equal status with medicine through increasing their level of academic knowledge and qualifications, therefore, is unlikely to succeed.

Closely aligned to this appears to be the belief that legitimacy = professionalism, with nursing attempting to legitimize itself as a profession aligned to medicine. Professionalism is commonly associated with a set of traits or characteristics which requires them to act in the best interests of the general public and is commonly referred to in terms of professional behaviour (Martimianakis et al., 2009). This simplistic definition has however been challenged by some who identify a more complex series of influences on the powerful position of medicine as a profession. One example is the institutional influence: for example the length of training involved (McDonald et al., 2005). The length of pre-registration nursing study for example remains shorter than that of medicine and has been cited by doctors as a rationale as to why they should hold greater power than nurses (Baker et al., 2011; McDonald et al., 2005).

As I highlighted earlier, types of knowledge also have an impact on the legitimacy of medicine and therefore it's high(er) standing as a profession (Eisner, 2002; Miller et al., 2008; Waddington, 2004). Nurses are, however, encouraged to achieve further academic credentials post-qualification. This enables them to undertake 'extended' nursing roles, such as that of the Nurse Practitioner and the Nurse Prescriber (NPs), undertaking tasks previously carried out by the medical profession (DH, 2000). To some extent, I would argue, this has enabled the goal of achieving greater legitimacy through additional academic credentials, to be

achieved. NPs have taken on extended roles, carrying out tasks previously undertaken by doctors and thereby achieving increased credibility and status (Snelgrove & Hughes, 2000; Harmer, 2010). However, whilst nurses undertake an extended role it is the medical discourse that continues to retain the higher status with the 'extended role' appearing simply to have turned nurses into 'mini doctors': carrying out the less complex medical tasks, rather than increasing the complexity of the nurse's role per se. Therefore, it is the status of the medical tasks that increases the NPs extended position rather than the nurses' role itself (Holyoake, 2012; Staerbek, 2012).

From this it appears evident that doctors continue to define the reality to which others have to adjust and conform. Setting 'boundaries' which are movable, for example, would appear to enable them to continue to hold ultimate control (Reeves et al., 2013; Staerbek, 2012). As such it could be argued that the additional roles carried out by nurses occur simply because doctors license the process (Fagin & Gaerlick, 2004). With the creation of the NP doctors are, for example, able to delegate more simplistic tasks and focus instead on more complex issues (Bailey et al., 2006; Holyoake, 2012) and thus ensure the medical hierarchy retains its dominant position.

Feminist theory also provides some insight into the doctor–nurse relationship, suggesting that the male–female power relationships are also reflected in those of the doctor–nurse relationship in the workplace. Historically women were originally excluded from joining the medical profession not by Governments but by the universities who acted as gatekeepers to the 'scientific' knowledge required in order to gain professional status until as late as the 1920s (Reeves et al., 2010; Walsh, 1977). Equally in relation to nursing women were historically discouraged from working with their role being considered as being to care for their children with their status in life earned through the position their husbands held (Walsh, 1977). Care-giving to the sick was seen as an extension of the woman's role within the home and prior to the formalization of the nursing profession women would naturally carry out this role informally and unpaid (Hall, 2005; Sweet & Norman, 1995; Walsh, 1977; Witz 1992). After the industrial revolution the role of the physician became established, with a fee required for his scientific, knowledge-based skills, and the woman's role in care-giving was devalued and discredited as health-provision was taken over by the male-dominated world of the medical (and scientific) profession (Walsh, 1977).

Nursing, it can therefore be argued, was historically created as a subservient role to medicine (Davies, 2003) with doctors being predominantly male and nurses female (Davies, 2003; Keddy et al., 1986). In a historical study, for example, Keddy et al. (1986) interviewed nurses who had worked in the 1920s and 1930s. These nurses described the influence that

doctors had over nurses, including direct involvement in their education, training and employment selection. This power differential mirrors the gender/class distinction of society at that time with women generally undertaking lower paid, less valued roles. Nursing continues to be made up predominantly of women, affecting how they are perceived by the medical profession, which has historically been predominantly male, with femininity considered to be a subordinate attribute to that of masculinity (Farrell, 2001). For this reason, the doctor-nurse relationship appears to be influenced by both gender and class/status relationships (Davies, 2003; Farrell, 2001). Described by Davies (2003) as 'doing dominance' and 'doing deference', the inter-related influence of gender (considered to be primary) and that of class and social position, has a significant impact on the unequal and oppressive relationships that women, and in this example nurses, experience in the workplace. Even when nursing is carried out by men, their role remains subservient to that of the doctor's because the identity of the nurse remains feminine, irrespective of the gender of the person in that role (Davies, 2003). Consequently the (feminine) nurse will inevitably be subordinate to the (masculine) doctor.

A significant influence on this dominance-deference relationship appears to be the nurses act of 'caring'. Caring is considered to be a feminine quality and an act that transcends both class and status. This same act is also considered to be a fundamental element of the nurses' role and is an extension of the maternal instinct and therefore an integral part of their identity (Davies, 2003; Porter, 1992). The nurses' identity has also been associated with different stereotypical and archetypal imagery which also appear to have been influenced by the caring attribute and is gender related. One such image is that of the 'mother earth' role (Farrell, 2001; Piertroni, 1991). This role, closely associated with that of a carer is considered to hold less power and status than that of the medical stereotypical role of 'curer' and as such reinforces female subordination (Farrell, 2001; Porter, 1992). Nurses who reject this role have been considered to be both 'bad' nurses and unfeminine (Farrell, 2001; Porter 1992).

Others also compare the role of the nurse to that of a 'mother' whose role is to nurture (Davies, 2003; Piertroni, 1991). As well as assigning the 'feminine' mother/nurturer archetypal identity to nurses, so too have 'masculine' attributes been assigned to the doctors. Piertroni (1991), for example, describes the doctor as a Warrior-God. Medicine, he argues, borrows metaphors associated with war to describe the masculine, aggressive, characteristics of medicine and doctors. These include phrases such as: 'the war against cancer' (p65); 'fighting the disease' (p65) and; 'stamping out infection' (p65). These phrases, which associate war with medicine, are also associated with strength and power and masculinity. Conversely, the identity of the nurse as mother and nurturer are strongly associated with the soft, feminine archetype of caring which lacks the power and force associated with the medical, masculine, identity of the doctor. Thus the imbalance of power

between men and women is carried through to the doctor–nurse relationship (Piertroni, 1991). Just as men exercise power over women as a whole, doctors, exercise power over nurses (Farrell, 2001; Keddy et al., 1986).

There has, however, been an increasing number of women entering the medical profession and this could be seen to influence the doctor-nurse relationship (Stein, 1990). Sixty percent of all medical students are now women and there has continued to be a steady rise in the number of female students entering medicine (Bleakley, 2013, Kilminster et al., 2007, Laurance, 2004). As a result the number of qualified female doctors is steadily rising. Whilst the percentage of women doctors is believed to be 40%, this rises to 54% of those aged under 35 (Bleakley, 2013). Consequently, concerns have been raised that this would lead to the 'feminisation' of medicine (Laurance, 2004; Lefevre et al., 2010). Despite this there is little evidence that it has yet to have a significant influence on the 'masculine' characteristics that underpin the medical epistemology of knowing. The traits that underpin medical knowledge, for example, are believed to be masculine-dominant traits, which continue to hold strength today (Clarke, 1983; Davies, 2003). Female students, therefore, are exposed to and expected to adopt the values and masculine characteristics associated with medicine and suppress feminine-associated attributes if they are to succeed (Davies, 2003).

Conversely, the nursing profession is predominantly female and historically nurses have associated their position of deference with that of their engendered position (Davies, 2003; Porter, 1992). However, there is a lack of tolerance from nurses towards authoritarianism in female doctors in comparison to male doctors, with nurses expecting female doctors to play a more participatory and equal role with nursing staff, rather than treat them as handmaidens (Davies, 2003). Despite this a literature review by Kilminster et al. (2007) found that there was little difference between the characteristics of male and female doctors, although women were encouraged and tended towards certain medical specialisms over others. For example, it has been noted that there are an increasing number of female doctors who have become GPs (Kilminster et al., 2007; Laurance, 2004). In addition within this specialism women reported being 'encouraged' towards particular areas of general practice, such as child and women's health, and what was considered the softer, more feminine (and therefore additional) roles (Kilminster et al., 2007).

Attempts have been made however to reduce the power of doctors and one way of achieving this has been through empowering patients through Government-directed changes and providing greater choice and say in health and their own health care. In doing so there has been an effort to move patients and service users from a position of compliance to one of concordance and therefore arguably shift the balance of power away from doctors (DH, 2000;

Coulter, 2002). The Bristol Inquiry (Kennedy, 2001) for example, listed 198 recommendations which were aimed at providing greater power to the patient/general public (Kennedy, 2001; Stinton et al., 2006). I discuss policy drivers further in the following chapter.

Summary

The increased importance placed on CP has resulted in doctors and nurses being in ever-more closer working relationships. Despite this the emphasis on their doing so effectively appears to focus mostly on the doctors and nurses themselves with limited consideration as to the wider influences that could impede it (Dickinson & Sullivan, 2014). The difficulties of working collaboratively appear to be further challenged by the lack of clarity as to what it is attempting to achieve and how it should be achieved (Warmington et al., 2004).

The culture of professional practice in particular appears to hold an historical influence on doctor-nurse relationships with the medical profession creating boundaries in order to lay claim to particular privileges which serve both to maintain their hierarchical position whilst simultaneously restricting access to others and is in contrast to that which CP appears to be trying to achieve (Baker et al., 2011; Witz, 1992).

Further historical influences appear to be bound up in what has been described as the 'doctor-nurse game' whereby nurses have learnt how to interact with doctors whilst seemingly continuing to respect a recognized difference in status (Stein, 1967; Stein et al., 1990). Attempts appear to have been made to address this in terms of increasing the academic capital of nurses and creating extensions to their roles (Snelgrove & Huges, 2000; Harmer, 2010). Despite this doctors seem to continue to hold power over nurses in terms of how they engage and control their work (Charles-Jones et al., 2003; Fagin & Gaelick, 2004; Jesson & Wilson, 2003). Whilst feminist theory has attempted to explain the continued power differentials between doctors and nurses, what I have tried to show in this chapter is that there seem to be a multitude of complex and diverse factors which can potentially impact on how they experience their relationships with each other. It is therefore important, I would argue, to draw on a wide variety of literature in order to understand the concept of collaboration better, including those from both an historical and sociological perspective. In addition it is important to look beyond the functionalist approach and consider collaboration from an emancipatory perspective: allowing both alternative and additional influences to be considered that can come to bear on the process of collaborating, rather than focusing simply on the outcome (D'Amour, 2005; Miller et al., 2008)

Chapter Two

Learning to Work Collaboratively

Introduction

In this chapter I will examine the growth of interprofessional education (IPE) in the United Kingdom (UK) and examine its relationship with collaborative practice (CP) from an historical perspective, identifying the Government policy drivers that established IPE and CP within mainstream contemporary practice and education. In the process, I describe how IPE legitimized itself as the predominant means of achieving CP in the future healthcare professional workforce. However, unlike CP, IPE does not have a commonly understood definition: "interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 2002) although there is a variety of ways in which it is implemented, varying both within the same, and across different fields. As with CP, there is also an extensive literature base relating to IPE which adopts a functionalist approach to evaluating its effectiveness. Again the findings are ambiguous with a limited evidence base with which to meet the positivistic criteria required within this approach (Reeves et al., 2010). Equally there is an additional body of literature illustrating the challenges faced in implementing IPE and again I will argue here that there needs to be an increased focus on the processes of IPE rather than the outcome.

I will also discuss the models used to deliver IPE in the primary care setting and will draw on the literature relating to work based learning (WBL) in relation to IPE in order to discuss its influence on interprofessional learning (IPL) in this field. In addition, I provide a brief overview of Bourdieu's theory of social life (1979; 1985; 1989; 1992; 1996, Bourdieu & Wacquant, 1992) giving a rationale to support its relevance to this study. As with chapter one, the focus of this study is on doctors and nurses and therefore the focus of this chapter will be on medical and nursing (interprofessional) education.

The History of Interprofessional Education and its Relationship to Collaborative Practice

Working practices have changed significantly over the post-war years with professions now being required to work in a diversity of collaborations (Fenwick, 2012) and frequently within the same physical location (DH 2000; 2005; 2010a; Hudson, 2007; Jesson & Wilson, 2003). Whilst CP appears to have gathered momentum in the context of the post-1990 spate of public inquiries into poor practices (for example: Kennedy, 2001; Laming, 2003) and developed further under the New-Labour Government (Dickinson & Sullivan, 2014) the first phase of CP development can be traced back to the 1970s and 1980s (Leathard, 2003).

Teams in the hospital setting have had a long tradition of working together (Piertroni, 1994). The drive for closer alliances across professional boundaries in the primary care setting, however, appears to have gained its first momentum under the publication of what was at the time the Department of Health and Social Security (DHSS) and the drive for closer collaboration between health and social services (DHSS, 1978). The division of services provided by the Department of Health and the local authorities at that time was recognized as particularly problematic in terms of meeting the needs of minority groups such as people with learning disabilities, the mentally ill and older adults whose needs commonly crossed the boundaries of these two separate authorities (Leathard, 2003). This need for closer collaboration in the primary care setting was re-enforced in 1984 with the establishment of inter-professional teams such as 'community mental handicap teams' which formalized the alliance of nurses and social workers. Focus on CP at that time, however, appeared to relate simply to working in a team rather than the wide and complex array of alliances often described as CP today (Barr et al., 2005).

At the start of the 1990s the focus on CP began to gather momentum amid concerns raised that it was fragmented: despite early efforts at achieving collaboration (Department of Health [DH] 1998) and that the power and authority of doctors appeared to put them beyond reproach by others (Kennedy, 2001; Smith, 2005). These conclusions were based on the results of high-profile Inquiries which highlighted poor inter-professional communications and the negative influences of the doctor's power on CP, resulting in deaths that could arguably have otherwise been avoided (for example: Kennedy, 2001; Laming, 2003; Radford, 2010; Smith, 2005). As a result of these Inquiries legislation was introduced which changed the way in which public health was organized. One aim of this legislation was to redress the power imbalance between doctors and other professionals and achieve a flatter team-based approach to health care and thus enhance the service provided to patients (DH, 2001a). To this end primary health care was developed based on the principle that it should be delivered in partnership with different members of the primary care team (Howarth et al., 2004; 2006). In addition, in terms of organizational infrastructure, the introduction of GP fund-holders was accompanied by the commissioning of health care within the primary care setting (DH, 2001a; Howarth et al., 2004). Although this power was lost with the introduction of Primary Care Teams (PCTs) (Charles-Jones et al., 2003) GP Practices remained independent with GP 'partners' being responsible for the Practice 'business' (DH, 2000). The introduction of National Service Frameworks (NSFs) (for example: DH, 1999; 2001c) further cemented the need for partnership working in this setting (Charles-Jones et al., 2003) and saw the move towards different professions being physically located within the one (GP Practice) setting (DH, 2000; DH, 2005; Hudson, 2007). In some areas 'LIFT' projects (Local Improvement Finance Trust) were introduced. These projects aimed to bring together a multitude of different

professions within one health care setting, with the aim being to provide an integrated service to patients and local communities (DH, 2005). This further reinforced the Government's philosophy that health care is best delivered collaboratively (Charles-Jones et al., 2003) and that collaborative practice is best achieved by locating different professions together in one physical space (Hudson, 2007). Despite this the delivery of CP remains complex with nurses in particular remaining ill-equipped to work collaboratively in the primary care setting (Howarth et al., 2006)

The introduction of IPE appears to be closely aligned to the growth of CP (Barr et al., 2005). As with CP it was the 1990s that saw IPE take root following the same public inquiries that preceded the establishment of CP as a key focus of contemporary care (Jinks et al., 2009) and as such gained support at Government level in the same way as CP (Barr & Ross, 2006). However, despite IPE now being an established means of supporting health care students to become 'collaborative practice ready' (GMC, 2009; NMC, 2010; WHO, 2010) there remains a lack of evidence to suggest that IPE does enhance CP (for example: Dickinson & Sullivan, 2014; Hammick et al., 2007). There has not, for example, been evidence of any reduction of child abuse cases since the formal introduction of CP (Dickinson & Sullivan, 2014) and more recent inquiries continue to highlight evidence of endemic neglect of patients (The Berwick Report, 2013).

The findings of Government Inquiries have influenced changes seen at national level into how health care is organized and regulated. Examples of these include the introduction of the Children Act (DH, 2004) and subsequently the Government Papers: 'Working Together to Safeguard Children' (Department of Education [DE], 2006; 2010; 2013) which called for greater collaborative working practices including shared assessment planning and multi-professional case notes. However, arguably the most significant legislation introduced was the NHS Plan (DH, 2000), which was driven by the findings from previous Inquiries which led the Government to acknowledge that the National Health Service (NHS) was outdated and needed to be restructured (Rushmer & Pallis, 2002). Described as a 'defining moment for health and social care' what followed was a major review of the NHS and its organization from one based on paternalism, to one based on consumerism (Gorsky, 2008). Changes to practices were proposed aiming to eradicate a hierarchical infrastructure and achieve instead a flat, team-based structure (Rushmer & Pallis, 2002; Charles-Jones et al., 2003). Indeed, the Government White Paper 'The NHS Plan' (DH, 2000) formally recognized the NHS as 'fragmented' and introduced a number of changes and initiatives in order to enhance partnership working between professions. Some of these initiatives have continued to be embedded in current practices today whilst others have failed to come to fruition.

One significant development in terms of enhancing CP proposed in this paper was the introduction of 'shared learning' between professions (DH, 2000). This proposal was also put forward by previous and later Inquiries completed around that time (for example: Kennedy, 2001; Laming, 2003; Radford, 2010). This same proposal was also subsequently supported by three Government Papers which laid-out a framework by which shared learning between professions should occur (DH, 2001a; 2001b). For pre-registration education this involved establishing a set of core skills and proposed shared learning from an early point in the students' (inter) professional journeys, including the introduction of a common foundation programme to facilitate student choice and movement between professional programmes (DH, 2000; 2001a). Emphasis was also placed on learning within the practice setting which was expected to include structured supervision and support for students (DH, 2001a; 2001b). However, whilst emphasis on practice-based learning continues to be proposed to date the introduction of a common foundation year has failed to come to fruition.

What has occurred has been the refinement of the concept of shared learning which has emerged into the pedagogical ideology now known as 'interprofessional education' (IPE) (Barr, 2002; Barr et al., 2011). At its outset, IPE was arguably ambiguous with a variety of terms (including shared and multi-professional learning) used to describe it. IPE is now a requirement of both medical and nursing pre-registration education (General Medical Council ([GMC], 2009; Nursing & Midwifery Council ([NMC], 2010) cementing its presence within pre-registration medical and nursing curricula.

Whilst the Regulatory Bodies require pre-registration programmes to include IPE in their curricula they fail to specify how it should be implemented (GMC, 2009; NMC, 2010). Barr (2007) previously proposed that the aim of IPE is three fold: to prepare students for collaborative practice; to improve team work and; to improve care. More recently the World Health Organisation (WHO, 2010) has attempted to provide further clarity by identifying six objectives or 'outcomes' they consider essential for achieving effective IPE. The first three of these are: communication, team working and understanding of roles of others. Additionally they identify the need for the learner to be: a reflective thinker; able to work collaboratively with patients and users and; appreciate the impact of stereotypical imagery on others' professions. Whilst this paper provides greater clarity as to the skills and attributes pre-registration health care professions need to be achieving under the auspice of IPE, there remains a need to ensure that the objectives of IPE and the over-arching goals of CP are married up effectively. Achieving this, however, remains problematic whilst the goals of CP remain unclear (Dickinson & Sullivan, 2014). Indeed, the findings from a recent systematic review found limited evidence that IPE would achieve this goal (Reeves et al., 2010).

Despite this there remains a strong view that IPE remains beneficial to CP (for example: Barnsteiner et al., 2007; Barrett et al., 2003; Fealy, 2005; WHO, 2010) although evidence from those that deliver it suggests that the practicalities of achieving this remain challenging. Indeed, most pre-registration learning continues to take place uni-professionally (Barnsteiner et al., 2007; Barr et al., 2014). When delivered however it has been suggested that it takes one of three approaches: didactic experiences involving the sharing of modules or specific learning initiatives; distinct projects or; practice-based initiatives (Fealy, 2005). Didactic methods, however, primarily use a teacher-centred approach with lectures often being used as the primary means of delivering content (Banning, 2005). However, it has been suggested that IPE initiatives should be delivered within an andragogical model (Barr et al., 2011) which draws on a student-centred approach (Banning, 2005) and small group numbers (Barr et al., 2011). This model of learning however can be challenging to adopt when large numbers of students are involved (Barr et al., 2011) and from my examination of the literature it would appear that most IPE initiatives generally involve large numbers of students undertaking separate professional programmes with often differing requirements (Barr et al., 2014; Freeth et al., 2001; Freeth et al., 2005; Dearnley et al., 2010; Gordon & Bywater, 2014; Hughes et al., 2004, Kamin et al., 2006, Pollard et al., 2014; Rees & Johnson, 2007) and frequently dominated by one (namely nursing) profession (Barrett et al., 2003; Bluteau et al., 2014; Dearnley et al., 2010; Hughes, 2014). Utilizing an andragogical model of delivery therefore appears to offer a number of challenges to those attempting to implement initiatives. For example an early study by Barrett et al. (2003) reports the difficulties faced in providing meaningful IPE to more than 700 students made up of unequal numbers of students from different professions, situated across disparate sites. Similar difficulties face educationalists to date with Pollard et al. (2014) reporting on the challenges experienced in attempting to deliver IPE to more than 800 students. The logistics become greater still when students are required to engage across campus' (Diack & Joseph, 2014; Pollard et al., 2014) and even between separate universities (Diack & Joseph, 2014). Other resourcing difficulties have been reported in relation to a lack of (appropriate): room availability (Gordon & Bywater, 2014) and; conflicting timetables (Barnsteiner et al., 2007; Dearnley et al., 2010; Diack & Joseph, 2014; Hughes, 2014). In addition logistical difficulties that organizers face are complicated by differing lengths of some pre-registration programmes over others (Pitt et al., 2014) and additional intakes that are out of alignment with others (Hughes, 2014). This has led to reports of IPE being delivered as a 'bolt-on' to the uni-professional curriculum (for example: Diack & Joseph, 2014; Gordon & Bywater, 2014; Hughes 2014) and/or predominantly via e-learning initiatives (for example: Anderson et al., 2014; Bluteau et al., 2014; Dearnley et al., 2010; Gordon & Bywater, 2014; Pollard et al., 2014).

These challenges appear to have influenced students' attitudes to IPE with reports of students struggling to see its relevance (for example: Bluteau et al., 2014; Dearnley et al., 2010; Gordon & Bywater, 2014) and an increase in negative attitudes towards students from other professions resulting in 'othering' (for example: Dearnley et al., 2010; Gordon & Bywater, 2014). Others suggest the power differentials that influence CP have a similar impact with students undertaking IPE as to that which can occur in professional practice and can equally result in 'othering' (for example: Fealy, 2005). Recognition of these issues has led to a call for a greater use of theory in order to frame the planning, delivery and evaluation of IPE initiatives (Hean et al., 2012) although to date there is limited evidence of this having taken place (Barr et al., 2014)

Negative attitudes have also been reported at faculty level (Barr et al., 2014) resulting in a general lack of support including lack of provision of (experienced) staff being provided to facilitate its delivery (for example: Diack & Joseph, 2014; Gordon & Bywater, 2014; Hughes, 2014) and an inconsistent approach to ensuring staff are suitably prepared (Barr et al., 2014). This has led to some proposing that IPE maybe better delivered once students have been established into their own professions (Charles-Jones et al., 2010; Dearnley et al., 2010; Hean & Dickenson, 2005) and in some instances has led to an abandonment of IPE initiatives altogether (for example: Bluteau et al., 2014; Hughes, 2014).

It would therefore appear that one of the challenges faced in delivering IPE using an adragogical model is the emphasis placed on the process of engagement. As the definition of IPE suggests, students should learn both with and from each other (CAIPE, 2002) and this generally involves students coming together in small groups (Barr et al., 2011) and is frequently incongruent in any sustained way with the large student numbers and logistical organizational challenges I identified above (Fealy, 2005).

Whilst the majority of IPE initiatives continue to be delivered within the university setting (Simpson, 2009) CP takes place in practice and therefore it could be argued that it is most appropriate that IPE occurs in this setting (Barr et al., 2014; Simpson, 2009). However although the number of initiatives that are being implemented in practice continue to rise the majority of 'teacher-delivered' initiatives continue to be delivered in the university setting (Barr et al., 2014; Pollard, 2009; Simpson, 2009).

Before discussing practice-based IPE however it is first of all worth my noting that there are recognized tensions with the terms 'formal' and 'structured' learning. Both these terms are generally considered synonymous with learning environments that are provided within the university setting and with a written curriculum which identifies how and when

teaching and learning will occur (Billett, 2004), involves a designated teacher or trainer, has formal learning objectives and, leads to the attainment of a formal qualification (Eraut, 2000). The use of these terms implies that learning which takes place outside of this curriculum is therefore 'informal' and 'unstructured' and as a result somehow inferior (Billett, 2004; Eraut, 2000). It further implies that learning can only take place within an environment specifically created for that purpose and therefore learning which occurs outside of that environment is either secondary or inferior in comparison (Eraut, 2000). Opportunities for learning, however, are both complex and heterogeneous (Collin et al., 2011). They can occur at any time during an individual's life and be both planned and spontaneous, depending on how and when learning situations present themselves (Billet, 2001a; Swanwick, 2005). Furthermore, as I will discuss later in this chapter, learning is actually more likely to occur outside of structured learning environments (Eraut, 2000) and has become commonly associated with the work place, particularly with regards to professional practice (for example: Kinsella, 2009; Williams, 2010; Yardley et al., 2012). For this reason I will use the term 'teacher-delivered' IPE to describe IPE that meet the criteria identified above. For learning that falls outside of this criterion, I will use the term 'non-formal' (as opposed to informal) as suggested by Eraut (2000).

As I stated above teacher-delivered IPE initiatives are predominantly delivered in the university setting (Barr et al., 2014; Pollard, 2009; Simpson, 2009) which appears to be due to the organizational tensions and logistical challenges faced in delivering IPE generally which is exacerbated further when decontextualized to the practice setting (Barr et al., 2011). In a recent survey for example it was found that only 35% of universities delivered IPE in practice as well as the university setting (Barr et al., 2014).

Whilst deliverers of IPE in the university setting face a number of difficulties the challenge of delivering IPE in the practice setting can be greater still and lead to restrictions on its delivery (for example: Hughes, 2014). In particular, students will be distributed across a wide number of practice settings in small numbers and follow differing clinical placement patterns due to differing models of curricula and Statutory and Regulatory Body requirements. These challenges can also be exacerbated further by the disparity in student numbers across different professions and the additional pressures placed on practice mentors (GMC, 2009; Hughes, 2014; NMC, 2010; Pollard et al., 2014). It is likely that due to these additional difficulties that when teacher-delivered IPE is implemented in the practice setting that it occurs in the hospital environment due to the larger numbers of students synchronously located in that environment in comparison to the primary care setting. This premise appears to be supported by published evidence. For example early practice-based IPE involved students working together on a specifically created 'interprofessional ward'. This approach was

pioneered in Sweden and later mirrored in the United Kingdom (Barr et al., 2011; Barr et al., 2014). Here, students from different professions collaboratively worked together to provide holistic care within the ward setting or spent time shadowing students from different professions. These types of initiatives were aimed at students gaining an increased understanding of each other's roles (CAIPE, 2002) as well as a shared understanding of interprofessional practice (Barr et al., 2011). These initiatives were, however, often resource heavy and only able to accommodate limited numbers of students at any given time. Morison et al. (2003), for example, described an evaluative (qualitative) study of students' structured, interprofessional learning experiences that was undertaken by all, (n = 130) in the university setting, but for a significantly smaller number (n = 52), involved in a shared, practice-learning experience in a ward environment. Freeth et al., (2001) also describe an 'interprofessional training ward' established to support the development of practice-based interprofessional skills: involving just six students at any given time and more recently Hughes (2014) describe how they had to abandon this model due to the unsustainable level of resources it involved .

An alternative approach from delivering 'teacher-led' initiatives is through the use of a project-based approach (Fealy, 2005). Used in the practice setting students can learn together in the clinical practice but through simulated situations, rather than synchronous, real-life issues. An initiative co-ordinated by the University of Leeds, for example, offered structured workshops delivered in the practice setting. These workshops took place in both hospital and community environments and used 'simulated patients' (actors) in order to help students enhance their (interprofessional) communication skills in relation to specific practice-based (scripted) scenarios (Kilminster et al., 2004). I used a similar principle in order to deliver a series of workshops to students from different professions, alongside trainee housing officers and women from the local, multi-cultural, community. In this initiative, one of my aims was for both students and local women to gain an increased understanding of the role of the different professions represented. Participants met in a local community centre in order to explore women's health issues through the medium of drama and art (Owens, 2008). In the Leeds project, the rationale appears to be one of convenience, as students are invited to attend workshops close to or within the clinical placement where they have been allocated (Kilminster et al., 2004). For similar reasons I delivered my art project in a local community centre. In my project however, the aim for holding the workshops in the community setting was not for ease of attendance of the students, but to encourage access for the local woman (Owens, 2008).

As IPE evolved, the focus of practice-based IPE has moved towards a competency-based framework (Barr et al., 2011). Despite this the numbers of students able to participate at any given time have remained small. One such initiative is described by Anderson and

Thorpe (2008) whereby students from different professions worked in interprofessional groups of just two to five with only one student group per ward in order to develop skills in CP. Using what Anderson et al. (2014) describe as a 'three strand model' students were encouraged to learn interprofessional skills incrementally which they then transferred into practice settings. They acknowledge, however, that this is not always possible. Steven et al. (2007) also describe small numbers of students working together, but their initiative used a tri-angled approach. As with Anderson and Thorpe (2008) the first of their approaches involved students working together in small inter-professional teams in order to develop their CP skills. Additionally these same teams (normally five to eight students) met together weekly for facilitated seminar-type tutorials, focusing on their practice experiences. The third approach they used involved a solitary student shadowing someone from a different profession. This final approach was used only in situations where no students from other professions were on placement in the same clinical area (Steven et al., 2007).

Interprofessional Education and Work Based Learning

Just as there are less examples of IPE taking place in the practice rather than the university setting, there are less examples of IPE occurring in the primary care rather than the hospital setting. Where IPE does occur in the primary care setting it often tends to occur using non-formal methods of delivery (Barr et al., 2011). This appears again to be due to the logistics of delivering IPE in this setting. This inevitably influences how IPE can be implemented. For example, the 'three strand model' described above used a ward-based initiative in the hospital environment, followed by seminar-type tutorials. In the community setting, however, students from different professions would visit service users, jointly, in order to gain a collective understanding of their health care experience and needs and then use a reflective cycle in order to appreciate the learning process better (Anderson & Thorpe, 2008). In abandoning the use of wards Hughes (2014) introduced instead a 'buddy-system' whereby students from different professions explored complex care issues that focused on both hospital and community-based scenarios. However, again due to logistical issues, this took place virtually. Another initiative undertaken in the community setting was the 'TUILP' Project. This joint initiative involving the University of Nottingham and Sheffield-Hallam University used a non-formal approach with facilitators employed in order to work with both students and supervisors/mentors in order to support them to understand, better, the interprofessional issues relating to their practice learning (Armitage et al., 2009; Jinks et al., 2009). Also using a non-formal approach, the Newcastle and North East of England pilot study encouraged a self-directed approach to student learning in the practice setting which involved no specific teacher-led involvement (Stinton et al., 2006). Pollard (2009) also describes a non-formal approach to learning CP. In her study there were no organized activities, nor involvement

from personnel outside of the placement area. Here, students were expected to learn CP skills using a self-directed work based learning (WBL) model. This form of learning has been recognized as an important element of pre-registration education and in particular in relation to learning CP-related skills in the community setting (Barr et al., 2011; Brosnan, 2010; Kinsella, 2009; Swanwick, 2005). For these same reasons it is this type of non-formal WBL – IPE upon which I will focus.

WBL is considered an effective model for facilitating the development of team working and CP skills (Moore, 2005) although it has been described (and understood) in different ways (Kinsella, 2009). Originally introduced in the 1990s it was first seen as a means of bridging the gap between theory and practice and of overcoming logistical barriers of enabling access to higher education to those who may otherwise have been restricted from doing so (Birch et al., 2005). It was also considered to be a way of overcoming practical barriers and the financial pressures of releasing practice staff for professional development (Moore, 2005). Since its conception it has grown in popularity and further benefits have been recognized, particularly in relation to those who need to apply their theoretical knowledge to practice-based situations (Cameron et al., 2010). More recently it has also been recognized as a student-centred process of learning which utilizes a combination of self-knowledge, formal learning and critical reflection, in order to meet the needs of both the learner and the workplace (Flanagan et al., 2000; Williams 2010). Different elements of this process, however, are emphasized by different writers. Moore (2005), for example, stresses the relevance of the self-management of the learning process. Billett (2001a) also focuses on the individual in his conception of WBL emphasizing the experiential journey students take in order to gain insight by: 'drawing on cognitive, sociocultural and anthropological conceptions' (2001a, p432). Others recognize the value of external influences. Yardley et al., (2012), for example, argued that WBL is a two-way process whereby the learner will not only actively gain understanding from the work-place but also give understanding to those within the workplace. Whilst different writers stress the importance of different elements of WBL the use of reflection remains fundamental to all although I will discuss this in further detail later in this section

These different descriptions and interpretations reflect the differing conceptual frameworks of WBL (Billett, 2001a) which in turn reflect the number of opposing theoretical perspectives on the nature of knowledge (Yardley et al., 2012). As I highlighted above when WBL first emerged it was considered a means of facilitating the application of knowledge to practice situations (Flanagan et al., 2000). It also focused on the attainment of clinical competencies (Dewar & Walker, 1999). The focus for pre-registration students however appears to be a 'transformative-cognitive approach' which, similar to IPE, focuses on the acquisition of competencies rather than a broader, epistemological focus on 'becoming' (D'all

Alba, 2009). This approach considers expertise to be achieved through the internalization of domain-specific knowledge whereby expertise is drawn upon in order to reach solutions to practice-based problems (Billet, 2001a). Whilst WBL plays a central role in medical education, for example (Swanwick, 2005), emphasis is placed on the exposure to experiences (Yardley et al., 2012) and the acquisition of competencies (Barr et al., 2011; Ladhani et al., 2012; Swanwick, 2005). Students are required to demonstrate an ability to apply scientific knowledge and principles to explicitly identified skills in clinical practice (GMC, 2009). In nursing education too, the attainment of competencies is considered significant (Barr et al., 2011; D'all Alba, 2009; Flanagan et al., 2000; Dewar & Walker, 1999). Here, the underpinning philosophy is that students will acquire knowledge that underpins their practice and that learning can and should take place in equal portions in both the university and practice setting (NMC, 2010). Both identify specific competencies that should be achieved and place great emphasis on evidence-based practice (GMC, 2009; NMC, 2010).

The application of a transformative-cognitive approach to WBL takes one of two forms. The first is 'skill-based' and its goal is to enhance a specific work-based skill and is often applied through the use of specific work-based training. The second form of WBL applies an andragogical model whereby the students identify their own learning needs, often through the use of a 'learning contract' (Williams, 2010). This second concept of WBL is based on the principle that the student is able to draw on knowledge developed through teacher-led learning experiences which will generally occur in the university setting. Students should then be able to contextualize, actively, the relevance of this learning into personal skill development within the clinical setting (Clarke & Copeland, 2003; Spouse, 2001; Williams, 2010).

There are, however, a number of assumptions that appear to impact on the ability of WBL to be utilized effectively with pre-registration students, which appear to make the use of a transformative-cognitive approach inherently flawed. One example is that this approach focuses primarily on skill acquisition and is based on an assumption that skills can be broken down into a series of simplistic tasks (Flanagan et al., 2000; Martimianakis et al., 2009). This reductionist approach to learning fails to recognize the processes involved in 'becoming' a professional (D'all Alba, 2009) many elements of which, as I will discuss later in this chapter, maybe invisible to the learner (Gleeson, 2010; Goldie, 2012; Holyoake, 2012) including the influence of power relationships on the (inter) professional learning process (Collin et al., 2011). Furthermore, whilst one principle of this approach to WBL is that it encourages learners to reflect on the implicit knowledge which influences practice (Dewar & Walker, 1999) it fails to make explicit the epistemological influence on how 'true' knowledge is constructed and contextualized (Billet, 2004; Gleeson, 2010; Goldie, 2012) As I will also be arguing later,

health care practice inevitably follows a routine which students quickly fall into, encouraging taken-for-granted, unreflective practice (Farrell, 2001; Nairn et al., 2012).

Another assumption is that the transformative-cognitive approach is based on the principle that knowledge can be categorized in order for relevant knowledge to be drawn on and applied to simple problems in novice learners and complex, non-routine scenarios, in 'experts' (Billet, 2001a). Learning, however, rarely takes place so 'neatly' but rather occurs through a complex, multifaceted, process (Swanwick, 2005) which requires them to be able both to problem solve and problem identify (Williams, 2010). This then assumes that learners will also be able to recognize learning needs and take responsibility for learning independently (Moore, 2005). However, this is a high-level skill that takes time and careful preparation in order to be achieved. Often neither is provided and practice placement times are too short for students to be able to achieve this (Williams, 2010).

What appears to be key to the use of WBL, using this assumed approach, is the learners' supervisor (mentor) whose role is to guide and support the learner through the learning process (Spouse, 2001; Williams, 2010) and identify opportunities for learning (Billet, 2001b). There appear, however, to also be a number of assumptions that influence the supervisor's ability to do this and therefore the effectiveness of the WBL approach. One assumption is that supervisors have the time, interest and ability to facilitate the student's learning process, in order for it to become meaningful. Often, however, this is not the case (Barr et al., 2014; Moore, 2005; Spouse, 2001) with some HEIs raising concerns regarding the additional burden this places on practice mentors and citing it as a reason not to use it in practice (for example: Pollard et al., 2014). A further assumption is that the supervisor has the relevant skills to provide the learner with constructive feedback. How and what is feedback, however, will inevitably influence how, when, what and if the learner learns from their practical experiences (Nairn et al., 2012; Swanwick, 2005).

In addition, the taken-for-granted practices that influence students' learning will also influence the supervisors' practice and therefore how they guide and direct their students. In particular it is likely that students will be immersed into a professional culture which will inevitably influence the ways in which they carry out their skills and undertake their role as a whole (Nairn et al., 2012). This in turn will intrinsically shape their professional identity (Holyoake, 2012). The findings from a previous study I undertook further support this. In my previous study I found that not only did students change as they continued through their professional programme, but that they were also unable to recognize ways in which they had changed as they become immersed into a professional way of 'being' (Owens & Dearnley,

2011). Similar findings have also been identified in other studies (for example: Chambers & Narayanasamy, 2007; D'all Alba, 2009).

An important element of the WBL model is the ability of the student to reflect, and an intrinsic element of reflective practice is praxis: not just the linking of theory with practice, but also the student's ability to develop new understandings of their world and as such, change practice (Nairn et al., 2012). In relation to medicine Witman et al. (2010) argue that what they describe as the 'hidden curriculum' of medicine (i.e.: the socialization into medical practices) is important in ensuring medical students internalize the culture of medicine in order to take on a medical identity. However if students are unable to recognize the taken for granted influences which shape how they engage with their professional world then it is unlikely that they will neither be able to reflect on practice nor act on it, as much of what is learnt takes place in a 'pre-reflexive', habitual way (Goldie, 2012). For example: in the ward setting patients follow a linear timeframe: being woken, fed and administered medications at set times throughout the day. Nurses then quickly learn the tasks they have to complete on a shift, facing criticism if these are not completed (Farrell, 2001) without, it has been argued, their even being aware that they have become immersed into a task-orientated regime (Nairn et al., 2012). Whilst holistic practices are taught in the educational setting there is often a disparity between what is taught and what is practiced. Students then become entrenched into these practices: setting aside what they are taught in order to conform to practice-based norms, without recognizing that that is what they are doing (Nairn et al., 2012). In this way they adopt the behaviours habits and cultural norms of their qualified counterparts in order to gain acceptance and approval from them, with no awareness that that is what they have done (Nairn et al., 2012). In a similar way it is likely that students will learn, implicitly, how to interact with other professions: adopting pre-established 'rules' of engagement that perpetuate pre-existing power (doctor-nurse) relationships (Baker et al., 2011; Collin et al., 2011)

It has been argued that in order to attain CP skills, students need to learn how to reflect from the perspective of other professions (Barr, 2013; Howarth et al., 2006; Wackerhausen, 2009). This requires students to spend time learning with and from students from other professions (CAIPE, 2002), yet WBL is often used in settings where there is just a single student (Barr et al., 2011) which suggests it is not conducive to this occurring as it reinforces the student's identity being molded by the uni-professional role models from whom they will both consciously and subconsciously learn (Goldie, 2012). Different professions are also taught within the framework of differing epistemologies of practice which influence what is valued most. Despite some suggesting that the divide between caring and curing has blurred (for example: Germov and Frejj, 2009), it appears that the caring element of the nursing role remains core and is reflected in their curriculum (Malloy et al., 2009; NMC, 2010). Conversely

in medicine the science-orientated elements of the curriculum are considered to be most prestigious and therefore likely to influence what is learnt (Brosnan, 2010), with the primary emphasis being on treatment and cure (Davies, 2003) and the patient viewed through a detached (medical) gaze (Foucault, 1973). In this way educational programmes influence not only what students learn, but also instill in them implicit values as to what is required in order to become a member of that profession (Malloy et al., 2009).

As each profession is grounded in its own epistemology of practice (Kotzee, 2014) students will be taught to interpret problems based on the beliefs and values that underpin that profession and current discourses of practice (Degeling et al., 2003; Martimianakis et al., 2009) which are reinforced through education and socialization (Billett, 2001a; 2001b). Hall (2005) describes this type of learning as 'indexing', whereby the learner organizes knowledge based on a set of rules. The way in which WBL is used will equally use domain-specific epistemologies of knowledge which are applied to solving problems in the practice setting (Billet, 2001a). For example, Nairn et al. (2012) argued that when reflecting on a particular situation choices are made as to what factors are considered to be relevant and what will be disregarded. These choices will be influenced by the student's personal and organizational value systems and the teachings to which students are exposed. The positivistic bases of 'diagnose', 'treat' and 'cure' which underpin medical education, for example, inevitably frame and therefore limit the decisions made within the practice environment (Davies, 2003). Conversely, it is considered that nurses examine practice from a caring perspective, which will equally frame and influence the decisions that they make (Malloy et al., 2009). As students learn, prior experiences and knowledge will further shape how new experiences are made sense of, constraining how problems are solved with them becoming further socialized into a particular professional identity (Davies, 2003; Degeling et al., 2003; Malloy et al., 2009; Yardley et al., 2012). Therefore reflection, it could be argued, is shaped by the professional practice into which students are submerged, as well as the profession-specific ways of working and thinking which then become normalized. Self-reflection, therefore, is also likely to be constrained at the outset by these professional boundaries of which the learner is likely to be unaware (Martimianakis et al., 2009). As I highlighted earlier, for students to be able to learn CP skills effectively it has been argued that they need to learn how to examine situations objectively: setting to one side their own epistemological viewpoint and considering issues from the standpoint of others (Barr, 2013; Wackerhausen, 2009). However, if much of what students learn is pre-reflexive and therefore learnt implicitly (Nairn et al., 2012) then this concept is problematic as it will be influenced by the epistemology of practice upon which their profession is based (Keddy et al., 1986). These implicit, taken-for-granted, traits then form an intrinsic part of the qualified professional's identity (Holyoake, 2012) who in turn form the role models for future students' learning (Goldie, 2012). Goldie (2012) describes this as

'regulatory power' (p642) whereby students of a given profession are subjected to the norms and rules associated with that profession, which are then reproduced in order to conform with those behaviours which are valued by the profession to which they aspire. Therefore whilst students' problem-solving abilities will not only be limited by the epistemologically framed knowledge base they are given in the university (Billet, 2001b), students' behaviour will also be reinforced in the practice setting by the feedback they receive from others when demonstrating those traits which are positively valued by their profession (Goldie, 2012). In addition, as I identified above, prior learning is suggested to be internalized and further constrains how students make sense of future experiences (Degeling et al., 2003; Malloy et al., 2009; Yardley et al., 2012). In this way students themselves also play a role in the development of their social identity through reflection and learning of past experiences in order to adopt a professional identity which conforms to the existing characteristics and traits of their qualified peers (Billet, 2001a; Goldie, 2012).

Equally, as I identified in chapter one, there is an extensive body of literature that has found the 'doctor-nurse relationship' to influence how each engages with the other which is bound up in a complexity of factors at team, organizational and macro level (Pullen, 2008). In being socialized into a particular professional identity, therefore, it is likely that students will also be socialized into how they engage with others (Baker et al., 2011), reinforcing rather than changing the hierarchical relationships that are already in place.

From the review of the literature provided above, it appears that there is much that can continue to inhibit how IPL occurs within the primary care setting and that it is intrinsically linked to the way in which CP takes place, and therefore CP as a whole. As I argued in chapter one, the way in which different professions interact with each other is likely to be influenced by the setting in which they work (King et al., 2013). In the primary care setting for example staff are less likely to work together synchronously than in comparison to the acute hospital setting and work with a wider diversity of patients and health care needs (Baker et al., 2011) as well as a wider number of possible professions and agencies (DH, 2005; Parrott, 200). What is significant about the primary care setting, however, is that doctors and nurses (and often other members of the multi-disciplinary team) are located together within the same geographical space, and work in ways which are not replicated in other parts of the health service (DH, 2005; Hudson, 2007). However, whilst the traditional, high-pressure, environments within the acute hospital setting are recognized as areas where interprofessional conflict can occur (Rosenstein & Naylor, 2012), the housing of different staff within one geographical space is also likely to have challenges in terms of interprofessional tensions for which staff maybe ill-equipped to effectively address (Howarth et al., 2006). Furthermore, whilst Stein (1967) and Stein et al. (1990) identified a number of factors that influence what

was described as the 'doctor-nurse game', the influence of physical space on their relationship was not included. And, with 90% of health care taking place in the primary care setting (DH, 2005) it could be argued that the focus on this environment is therefore important (Barr, 2002).

In this study I use Bourdieu's concept of social and physical space as a means of exploring power and hierarchical relationships. Bourdieu uses social space as a means to explaining how groups hold a position of power and how power and hierarchical relationships are maintained (Bourdieu, 1979). Power relationships, Bourdieu (1985) argues, are present in the mind and influences how different groups make sense of their world: depending on their hierarchical position within it. The distribution of groups within a given physical space will reflect the social space between them (Bourdieu, 1989). In this way the position a group occupies within a given physical space reflects the power they hold and the hierarchical position they occupy in relation to others (Bourdieu, 1996). In relation to this study, therefore, I use social and physical space as proxies for the concept of power and hierarchical relationships.

As I identified in chapter one, much has been written about doctor-nurse relationships and the powerful position of the former in relation to the latter. Despite this, the influence of space on CP has raised limited interest generally. The French philosopher Pierre Bourdieu (1979) has argued that space has significant influence on power and hierarchical relationships. Agents, he proposes, can be physically located within one physical space yet remain socially distant. This social distance, or space, will be influenced by the amount of power (described as capital) agents hold. The work of Bourdieu will be discussed in greater depth in chapter three and identifying, in chapters four and five, how it has been used to aid understanding in this study.

Although there has been an increasing interest in the use of Bourdieu to provide new insights into professional practice (for example: Barr, 2013; Goldie et al., 2012; Lynam et al., 2007; McCloskey, 2011; Nairn et al., 2012; Witman et al., 2010), limited work has been undertaken to explore the use of space on CP. One study which was carried-out was undertaken by Gum et al. (2012). This study drew on the work of Bourdieu to examine the influence of the nurses' station on CP, exploring how the physical presence of the station itself influenced how nurses interacted with different health care professionals. However, this study did not focus on the doctor-nurse relationship specifically and was undertaken in the acute hospital setting, rather than primary care. Miller et al., (2008) also discusses the use of the nurses' station in her study, but focuses on the domination of doctors within this space and the lack of status related to the emotional work of nurses. This study was not undertaken using a

particular theoretical perspective. Similarly Green (2013) also explored the use of space (considered in his study as part of the broader theory of 'relative distancing') on CP. This study, however, explored the use of space (distancing) from the students' perspectives, rather than in relation to CP. This study was also undertaken in the acute hospital. No medical students were included in this study which involved both theoretical and practical elements of the students' experiences. Conversely Brosnan (2010) used Bourdieu to examine the influences of medical schools on students' learning, but compared the influence of different schools on the learners' experience, rather than the influence of medical education itself. A further study by McCloskey (2011) compared nurse–nurse relationships. This study explored the influence that different work settings and patient groups had on the social capital of those involved. Other studies have also looked at the influence of space in the health care setting but not specifically used Bourdieu as a tool to add interpretation of its meaning, nor focused specifically on doctors and nurses. One such example is the examination of space on psychiatric patients in comparison to nurses in an in-patient setting (Andes & Shattell, 2006). Others have provided a critique of the work of Bourdieu, or of specific aspects of it (for example Colley & Guéry [*in print*]; Kim, 2010) and others have examined its use as a means of facilitating research itself (for example Slembrouck, 2004). One example of the latter was a study by Paradis and Reeves (2013) who used Bourdieu as a theoretical framework in order to examine published studies relating to CP and consider whether research in this field has increased legitimacy in the academic field. Whilst focusing on CP, however, it only uses Bourdieu as a tool to consider the research papers rather than CP itself. Thus, I would argue, using Bourdieu's theories in order to explore collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting, is timely.

Conclusions

The third and final question identified at the start of chapter one was to ask what factors impact on the use of non-formal interprofessional education with medical and nursing students in the primary care setting. IPE however is inextricably related to CP and as such it is important to consider this in relation to the way that professional staff conduct their relationships: whilst also exploring those factors that can impede this taking place. Although IPE has a recognized definition (CAIPE, 2002) the lack of clarity regarding what CP is and how it should take place makes evaluation of IPE outcomes problematic.

Examination of existing IPE initiatives also confirms the continuing challenges in delivering it effectively. Greater emphasis therefore needs to be placed on the process of IPE

in order to better understand what impacts on it occurring. Indeed a wide and complex array of factors can influence both how and if it is delivered (Bluteau, 2014; Hughes, 2014) not only in the university setting but also in practice where its use in the primary care setting can be particularly challenging due to the limited numbers of students available at any given time (Barr et al., 2005).

Equally the way in way CP is conducted in this setting can also influence its effectiveness. Although conflict between the professions is known to be particularly evident in traditional areas of health care delivery (Rosenstein & Naylor, 2012), the positioning of different professionals in close proximity to each other in the primary care setting also brings with it its own challenges: particularly when it has been suggested that nurses in particular lack the skills in order to engage effectively (Warmington et al., 2004; 2006).

The use of non-formal learning in this field also brings challenges. Whilst there is a reliance on mentors to support students, for example, there is a failure to recognize that they maybe ill-equipped to do so (Spouse, 2001). This assumption also ignores the heterogeneity of the primary care setting as a learning environment whereby learners are likely to learn in non-formal ways from the situations to which they are exposed through engagement with and in their environment on a day to day basis (Billett 2001a; 2001b; 2004; Collin et al., 2011; Guile, 2011).

I would argue therefore that Bourdieu's theory of social life (1979) provides a useful lens with which to explore what is happening with regards to students' learning in this environment. In particular because of the influence of the doctor's position of power in relation to nurses that I have described here. I provide a detailed overview of Bourdieu's theory in the following chapter: arguing for its appropriateness for this field.

Chapter Three

The Methodological Process

Introduction

In this chapter I will describe the methodological processes I followed, having provided the contextual background for the study in the preceding chapters. I describe the framework I used, the theoretical lens, the methodology, methods and process of analysis, providing a rationale throughout for the decisions I made. I describe the findings from my study in the following two chapters.

The settings I used for this study were three General Practices (GP) with participants taken from the staff working in them as well as students undertaking, or who had recently undertaken, a placement in one of the Practices. The Practices and therefore the participants involved in the study, were selected purposively.

I collected the data using a combination of focus groups, observations, field notes and a reflexive diary. In addition I undertook two in-depth interviews due to restricted participant availability which prevented me carrying out a focus group on those occasions. For the focus groups I divided the staff into three groups: administrators, general practitioners (GPs) and nurses, with nurses further divided into subgroups of district nurses (DNs), health visitors (HVs) and practice nurses (PNs). I undertook 18 focus groups involving 151 participants. In addition I undertook observations at each of the Practices involved in the study in order to gain greater insight into what was happening. I also made field notes during and shortly after the observations and kept a detailed reflexive diary throughout. I used the reflexive diary in order to record personal thoughts and reflections and to help guide me through the analytical processes and make sense of the data. Following completion, I transcribed each of the focus groups and the in-depth interviews verbatim and uploaded them into the software package NVIVO8. I then used template analysis as a framework in order to facilitate the initial process of organizing the data in a systematic way. I will describe these processes in further detail within this chapter.

The Research Framework

I chose to frame my study as a critical ethnography, which is a sub-group of ethnography, as I felt it sat comfortably with the explorative, inductive, study I had chosen to undertake (Atkinson & Hammersley, 1994). Originally used solely in the field

of anthropology, ethnography was made popular by Malinowski and other early anthropological fieldworkers as a means of studying distant cultures (Holmes & Marcus, 2005). Evolving into what is currently recognized as ethnography it was originally made popular as a methodology in its own right by the Chicago School of Sociology in the 1920s (Baszanger & Dodier, 2004; Delamont, 2007; Madison 2012) by researchers such as Park, Dewey and Mead (Creswell, 2007) and is now an established approach popular in a number of different fields including that of nursing studies and the social sciences (Delamont, 2007). Ethnography is concerned with the study of people and their cultural practices in their natural settings, the relationships between people within them and the impact that the characteristics of that environment has on the people within it (Baszanger & Dodier, 2004; Baumbusch, 2011). More recently ethnography has evolved to comprise of a number of pluralistic sub-groups with contrasting theoretical foci and aims. Some of these sub-groups include ethnomethodology, feminist ethnography as well as critical ethnography, which I use in this study (Atkinson & Hammersley, 1994).

Part of the aim of ethnography is to elicit the individuals' perspectives on factors relating to elements of social reality (Altheide & Johnson, 1998) which is achieved by the researcher through immersion into the culture under study (Sarantakos, 2013). Entering the world of the participants the ethnographer, as an outsider, is able to observe the everyday social lives that are habitual and taken-for-granted by its members (Sarantakos, 2013). Ethnography in its original form, however, has been criticized for failing to take into consideration the political and cultural influences on individuals' lived experiences (Allen et al., 2008; Foley & Valenzuela, 2005). In the 1960s, however, critical ethnography emerged as a methodology based on the principles of critical inquiry (Foley & Valenzuela, 2005).

Often using multiple epistemologies critical ethnographers can draw on eclectic ways of knowing (Foley & Valenzuela, 2005). To achieve this field methods are used to examine patterns of individuals' or groups' lived experiences and identify the cultural systems of power and authority that influence them in order to elucidate change (Allen et al., 2008; Denzin & Lincoln, 1998; Porter & Ryan, 1996). In addition it aims to identify hidden agendas and explore taken-for-granted assumptions that influence everyday practices. In doing so it attempts to highlight systems of power and control that create a power-imbalance in individuals' lives and ultimately challenge the status-quo by giving voices to the subjects being studied (Baumbusch, 2011; Bransford, 2006; Madison, 2012). The researcher achieves this through an in-depth exploration of the culture influencing the naturally occurring behaviour of individuals and groups and how,

through their behaviours, these influences are either sustained or challenged (Allen et al., 2008). The position of the researcher using this approach therefore is one which stands against hegemony whilst identifying the effects of the current position (Madison, 2012). Analysis using this methodology, therefore, takes place in order to make further sense of what is happening and to consider phenomena in relation to systems of power and control (Allen et al., 2008).

Using this approach it was important for me as the researcher to also recognize my own position in relation to what (and who) I was studying, ensuring my voice was heard throughout the analytical process and my own values and beliefs clearly articulated (Denzin & Lincoln, 2005; Field & Morse, 1985). In relation to this study I began with a belief that the historically dominant position of the doctor could negatively impact on collaborative practice (CP) and that this could influence how both professionals and students experienced CP in the primary care setting (Fenwick, 2012; Haddara & Lingard, 2013).

Whilst recognizing at the outset the dominant position of others it was also important that I recognized my own power in relation to my position as the researcher (Creswell, 2013). In many forms of qualitative research the most important 'tool' is that of the researcher as they simultaneously attempt to understand what is happening in the field as well as demonstrate they have interpreted it correctly (Madison, 2012). Using critical ethnography however means that it is important for the researcher to acknowledge their own background, powerful position and authority. How the researcher thinks and feels about the world around them, for example, influences their engagement with it. In this way it is important for the critical ethnographer not only to consider the perceived acts of dominance around them, but also their own position of power as a researcher (Madison, 2012). This position is considered in relation to others and how this informs the dialogue. Described as an 'ethnographic presence' (Madison, 2012, p11) meaning is represented through interactions with others and is represented as such, rather than simply as a monologue (Madison, 2012).

As an inside-researcher, it is the researcher that makes sense of and gives meaning to the world they are exploring, achieving this representation through a familiarity with the environment and subjects being studied (Allen, 2004): identifying connections through a complexity of rich data and therefore providing validity (Denzin & Lincoln, 2005). Rather than achieve this through the positivistic concept of triangulation and that of a 'one truth', however, validity is achieved through a multi-dimensional

exploration of the findings whereby multiple truths are recognized as being equally valid (Denzin & Lincoln, 2005; Richardson & Adams St. Pierre, 2005). Using multiple-methods therefore aids the achievement of richness and depth to the study (Denzin & Lincoln, 2005) as the researcher's voice acts as a powerful tool (Richardson & Adams St. Pierre, 2005) providing multi-faceted accounts of what is happening in the field (Richardson & Adams St. Pierre, 2005). To achieve it the researcher engages in what is known as a reflexive gaze in order to become self-aware and look inward on themselves, exploring how they are undertaking the research whilst it is occurring and ensuring ownership of their own perspective (Allen, 2004; Clancey, 2013). It is also used as a means of considering one's own attitudes and thoughts towards each element of the research process, including aspects they may have taken for granted (Clancey, 2013). As such it provides transparency of the analysis whilst recognizing the role of the researcher as an essential 'tool' in the research process (Allen, 2004; Foley & Valenzuela, 2005). Reflexivity, therefore, can be one of the most powerful elements of the research process as it can be used to guide the reader through the rich data that was gathered and facilitate the reader's journey in understanding how meaning was achieved (Foley & Valenzuela, 2005). I will discuss the reflexive process later in this chapter as well as provide examples as to how I used it in this study.

Bourdieu's Theory of Social Life

Validity of positionality is also facilitated through the use of a recognized theoretical framework (Allen, 2004). Whilst I used critical ethnography as my methodology, I also drew on the work of Bourdieu (1979) to act as a theoretical lens and aid my understanding of what was happening within the field. Using theory helps the researcher to understand what is happening by viewing it from a particular perspective. That perspective can be multi-paradigmatic in focus (Denzin & Lincoln, 2005). I chose both critical ethnography and Bourdieu's theory of social life (1979) as I believed they sat comfortably together: both sharing similar fundamental beliefs. For example both focused on the importance of linguistics and took as their main theoretical concepts power relationships, taken-for-granted behaviours and the influence of power influences on them. Bourdieu, for example, introduces the concept of unconsciousness in the form of the 'habitus' which he describes as the conditioning of individuals through the socialization into public norms which reproduces itself through their social history in the form of a disposition (Bourdieu, 1979; Dreyfus & Rabinow, 1993). Behaviours perceptions and ways of thinking and of doing emerge from individuals through an internalized schemata which becomes enacted as second nature (Krais, 1993). This

disposition is equally objectified by the social infrastructure. In the same way the 'habitus' keeps these dispositions alive both by acting out a lived experience through the social infrastructures imposed on it in terms of having a 'sense of own's place' (Bourdieu, 1989, p17), as well as regulating those same infrastructures in a certain manner imposed on it by the infrastructures themselves (Krais, 1993). Thus individuals both influence and are influenced by a structuring-structure which takes place beyond their level of consciousness (Bourdieu, 1979). As I identified in chapter two it is likely that students would unconsciously learn patterns of behaviour from their qualified peers which would influence how they engaged with others (Coombs & Ersser, 2004). Using critical ethnography as my methodology enabled me to adopt a particular position and approach as the researcher: i.e.: my position was not a neutral, passive, one as with alternative theoretical positions I could have taken (Fetterman, 2012). However, by using Bourdieu's theory of social life (Bourdieu, 1979) as a theoretical lens I was able to explore not just what was happening, but also attempt to understand why it was happening too. I attempt to demonstrate how his theory helped me to achieve this in the following chapters.

Bourdieu argues that society should be considered as a number of sub-sets: each conforming to a number of both generic and field-specific principles. These principles act as laws which are understood and practiced, implicitly, by those who have an interest or a stake in a field to the extent that they become an inherent aspect of their habitus (Bourdieu, 1992; Bourdieu & Wacquant, 1992). These field-specific laws are each closely aligned to the particulars of the field and its structure: which is itself influenced by the power relationships of the individuals, or institutions, within it (Bourdieu, 1992). Thus previous and ongoing struggles to gain power and authority influence the structure of the field (Bourdieu, 1992; Bourdieu & Wacquant, 1992). Bringing together the different professionals under the one roof of the GP Practice was considered appropriate, at a political level, in terms of enhancing CP (DH, 2005; Hudson, 2007). However in doing so I would argue that it appears to ignore the previous (and ongoing) differences in power relationships between the doctor and the nurse and the influence this has on the way in which each interact when housed in close proximity. By adopting a particular position as a researcher (i.e.: using both critical ethnography and Bourdieu's theory of social life) I anticipated that I could explore the impact that status and organizational influences had on CP and those housed together within the physical location of the GP Practice.

The concept of capital is significant to Bourdieu's work (Bourdieu, 1992). Capital, he argues, can be either generic or field-specific and either real or symbolic. Possession of capital however is associated with power giving those who hold it hierarchical influence over those with less or no capital (Bourdieu, 1992). Thus whilst some capital provides power across any field the capital of others is recognized only within a given field (Bourdieu, 1992). As I previously stated my starting point for this study was the belief that the (higher) status of the doctors had a significant (negative) influence on CP. Applying Bourdieu's theory of capital (Bourdieu, 1992) to my field under study would help me, I believed, in gaining an understanding of the influence of the doctor's status on inter-professional relationships.

Bourdieu argues that fields can be analyzed independently of those who populate them although those who do populate a given field must have an interest in it in order for it to function effectively (Bourdieu, 1992). In this way both are inextricably inter-connected through the individual's habitus (Bourdieu, 1992). In considering how a field functions, Bourdieu argued that it can be likened to a game having both generic and field-specific rules (Bourdieu, 1992; Bourdieu & Wacquant, 1992). The field and therefore the game is socially constructed (Bourdieu & Wacquant, 1992). In order for the game to work individuals need to have a motivation to play or an investment in the game (the *illusio*) and the necessary skills in order to play it (Bourdieu & Wacquant, 1992; Colley & Guéry, *in print*). In addition, they must also conform to these rules in order for the field to function successfully. In doing so they are, by their very conformity, accepting the value of the game and that it is worth playing (Bourdieu & Wacquant, 1992; Colley & Guéry, *in print*). Even when rules are challenged the challenge itself tends only to take place within the parameters of the game thus continuing to recognize the value of the game by conforming to the rules and enabling the 'game' to be kept alive (Bourdieu & Wacquant, 1992). In this study I considered the three GP Practices to be my 'field'.

Bourdieu further argues that social and physical space shares a number of similarities. For example just as individuals are located in one physical space they are also located within one social space. The presence in one space therefore is mutually excluding or distinctive from others. Equally the location of an individual in one (physical and/or social) space can be characterized by its position in relation to other spaces (Bourdieu, 1996). Social and physical spaces also retain a number of similarities which make them interconnected (Bourdieu, 1989; 1996). The positioning of groups within a physical space for example will be influenced by the social space between them

(Bourdieu, 1989; 1996) and by the quantity and weight of capital that each group holds (Bourdieu, 1996). Therefore, the social position of groups translates into 'position taking' (Bourdieu, 1996; p14) whereby the physical space occupied will correspond in value to the capital held by a particular group. This then becomes reflected in the habitus which creates a distinction of characteristics of a particular group and between different groups (Bourdieu, 1996). However, whereas physical space is physically visible and therefore clearly defined, social space is invisible and is often masked by the physical manifestations of physical space (Bourdieu, 1985; 1996). I will provide examples of this in chapter four. In choosing a field for my study I believed that the GP Practice provided a defined physical location, housing three different 'professions', each with a previously recognized hierarchical position in relation to the other. Therefore I considered it to be a valuable field for the purposes of my study.

An intrinsic aspect of Bourdieu's concept of the game is a focus on language and the way in which individuals interact within a given field (Bourdieu & Wacquant, 1992). Heavily influenced by the work of Heidegger, Bourdieu considers language through a multitude of inter-connected factors that transcend disciplinary boundaries (Bourdieu & Wacquant, 1992). The laws of a given field, for example, will influence not just what is said but also who can speak who can speak to whom and who must remain silent (Bourdieu & Wacquant, 1992). These same laws will also give weight to what is being said which is relative to the social position of the person who has spoken (Bourdieu, 1992). The higher their social position the less importance is placed on what is actually being said as their position is sufficient to portray the fact that they have the authority to speak. Thus significance is placed on who is speaking and it is this which gives weight to what is being said rather than the spoken words themselves. Where the authority is significant and the social space between the speaker and the listeners is greatest the 'speaker' need not even speak at all yet conveys their position simply because of the authority that they hold (Bourdieu, 1992). In this way all interactions will be influenced by the power relationship between those involved (Bourdieu & Wacquant, 1992).

The enactment of these laws however occurs at a subconscious, taken-for-granted level, which is influenced by the social space between individuals. Thus interactions occur within a 'social order' frequently accepted for what it is (Bourdieu, 1986). Individuals are generally accepting of their social position and in doing so do not challenge the parameters of it (Bourdieu, 1996). For this reason the study of language is not considered in isolation but examined in relation to a given field and the influences

of the hierarchical relationships within it (Bourdieu & Wacquant, 1992). In relation to this study I will use this concept of language and the power(ful) influence it has in order to explore both how the different professions speak about, as well as to, each other.

Bourdieu (1996) argues that the mastery and use of a particular way of communicating will give individuals authority to speak. Described by Bourdieu as 'linguistic capital' language is used to the speaker's own advantage to relay the fact that theirs is a voice of authority (Bourdieu, 1992) and is a reflection of their embodied lifestyle or 'habitus' (Bourdieu & Wacquant, 1992). Particular ways of speaking are then used to either separate oneself (above) from others, or affiliate oneself with others of a particular class. Thus social positions and space are reinforced through the linguistic capital used (Bourdieu, 1979). I felt Bourdieu's concept of social positions and the embodied lifestyle to be particularly relevant to this study due to the historical, hierarchical, demarcations between doctors and nurses that I described in chapter one (Witz, 1992). In particular Bourdieu (1985) describes a 'space of relationships' (p725) that differentiates classes and comes about through a natural order. Through an examination of the literature it appeared that this same natural order continued to be evident in contemporary practices and as such was likely to influence both how doctors and nurses conducted their relationships with each other as well as the students' experience of non-formal IPE in the primary care setting.

As I identified earlier in this chapter I considered the three GP Practices as the 'field' for this study and the staff and students within them as the participants. In doing so I believed it likely that the participants would have established laws of engagement (collaborative practice) (Bourdieu, 1992; Wacquant, 1992) which would be influenced by power relationships within this socially constructed environment (Bourdieu & Wacquant, 1992). Described by Bourdieu as 'symbolic violence' (1989; p21) the implicit laws within a given field will create a legitimacy of hierarchical relationships as all involved accept their position within the field and adopt ways of interacting which confirm their having brought into 'the game' (Bourdieu, 1992; Bourdieu & Wacquant, 1992). As I identified earlier, whilst the housing of different professions under the one roof of the GP Practice came about due to the belief that it would enhance CP (DH, 2005; Hudson, 2007) it has been argued that those who are directly employed by the GP hold a lower status than them yet are expected to contribute as an equal to the GPs as part of the multi-professional team (Barr et al., 2005; Smith & Walshe, 2004). Therefore, whilst the focus of this study was on doctors and nurses (and the education of students), I also included GP Practice administrators in my study. Evidence from a previous study had

identified that they held a low social position within the GP Practice despite providing a significant contribution to the multi-professional team (Owens et al., 2007). Therefore I anticipated that they would provide additional, valuable, insight into the influence of hierarchical relationships and the 'game' (Bourdieu & Wacquant, 1992). Although I recognize that they did not represent a 'profession' per se I will refer to them as such for ease of reference within this study.

In examining power relationships Bourdieu (1989) also suggests that categorization takes place continually in the minds of those interacting which results in a natural grouping of individuals taking place. Identifiable differences such as ways of speaking, clothes worn and general mannerisms will emerge out of these established groups, forming symbols which can be used to identify and classify specific groupings (Bourdieu, 1979; 1989). This shared identity also reflects the way in which these groups then view and make sense of the field in which they are immersed (Bourdieu, 1989). Described as 'tastes', the way in which groups interact with the field will be reflected in their distinctive tastes which translates into specific behaviours (Bourdieu, 1979). However rather than simply being tastes of choice for those with least power and influence these tastes reflect what Bourdieu describes as a 'forced taste' (1979; p178) whereby choices are self-restricted and based on limitations reflecting their social status within a given field. These tastes then influence individual aspirations which are self-restricting and reflect the social position that they hold (Bourdieu, 1979). For GP administrators I considered that these would be most evident due to the recognized low hierarchical position that they held further confirming to myself the value of including them in this study (Owens et al., 2007).

By using Bourdieu's theory of social life, and particularly his theory of social and physical space, as a proxy for power relationships, I believed that I would gain new insights into what is happening in practice and what influences students learning, their unconscious adoption of profession-specific cultural norms and, their use of non-formal IPE. For example, as I identified in chapter two, students most commonly use an approach called 'work based learning' (WBL) as a means of engaging in IPE in the primary care setting due to limited numbers of students situated in one clinical area at any given time (Barr et al., 2011). However it is likely that students will commence their programmes of study with pre-conceived affiliations to their chosen profession and stereotypical beliefs relating to others (Piertroni, 1991). This affiliation is likely to be further reinforced throughout their programme of learning as they become sub-consciously immersed into the cultural norms associated with their chosen profession

and adopt the implicit values associated with it (Chambers & Narayanasamy, 2007; D'all Alba, 2009; Goldie, 2012; Nairn et al., 2012; Owens & Dearnley, 2011; Wackerhausen, 2009). This is likely to influence how they learn to engage with other professions through collaborative practice.

The Study Sample

Whilst the theoretical framework facilitates the positionality of the researcher (Madison, 2012), it is the methodological design which aids the completion of the research process (Madison, 2012). The aim of sampling in some types of qualitative study is to create and develop categories which are used in the process of developing theory and in this way the sample selected forms an important part of the research process and the overall validity of the study (Sarantakos, 2013). Participants, or groups, are selected purposively allowing the researcher to ensure that the sample being studied meets the criteria for selection: i.e. towards suitability for the study rather than representativeness (Sarantakos, 1998). This was also my aim here. In particular my decision to include three Practices in the study was taken to ensure it met the criteria laid out in Table One below and enable access to a greater number of the student population.

Table 1: Criteria used for my selection of GP Practices

1. GP Practices were located within a specified, local, city facilitating ease of access;
2. GP Practices within this locality provided clinical placements to both medical and nursing students;
3. Nursing students were from the university to which I was affiliated;
4. GP Practices had not participated in a previous research study in which I had had previous personal involvement;
5. The Practice(s) involved in the study should be the permanent or main base as some had satellite bases where they were also required to visit
6. I would not have any personal affiliation to the GP Practice for example where I was registered as a patient
7. GP Practices were willing to participate in the study

Clinical placements in the primary care setting generally involve small numbers of students at any given time (Barr et al., 2011). This was also true in the area where I carried-out this study and particularly with regards to the nursing students

whereby only one or two students were placed with a nursing team at any of the Practices at any given time, thus limiting the participants available.

Entering the Field

Four GP Practices met criteria one to six and were initially all approached by myself by telephone, via the Practice Manager, and invited to participate in the study. I chose this method of communication because I recognized it as an effective means of gaining further access (Chell, 1998). Of these four one declined to participate due to staffing shortages leaving the remaining three. For ease of reference I will refer to these as Practices One, Two and Three. I then proceeded as follows:

Practice One

I spoke on the telephone to the Practice Manager (PM) and provided an outline of the study. The PM gave me permission to proceed with the study. I then sent the information sheet and consent forms for the study via email with an agreement from the PM that these would be circulated to all members of the Practice staff prior to their participation.

Practice Two

I spoke on the telephone to the PM and provided a verbal outline of the study. A face-to-face meeting was then set-up in order for me to provide them with further information pertaining to my study. The PM, alongside a senior partner of the Practice, was present at this meeting. From this they requested that a further meeting be set-up with members of the whole Practice in order for me to describe the study further and gain their consent to participate. I took information sheets and consent forms to this meeting and circulated them to all present with an agreement from the PM that they would forward copies of these to anyone not present.

Practice Three:

I spoke on the telephone to the PM and provided a verbal outline of the study. A face-to-face meeting was then set-up in order for me to provide them with further information pertaining to my study. As with Practice Two a senior partner from the Practice was present at this meeting. I took information sheets and consent forms to

this meeting and circulated them to all present with an agreement from the PM that they would forward copies of these to anyone not present.

I found these initial conversations useful not only in enabling me to provide the Practices with information regarding my study but also to help me begin to gain some insight into how each of the Practices functioned. I therefore began making field notes and keeping a reflexive diary from the outset, the purposes of which I will discuss later in this chapter.

I found the characteristics of the three Practices had aspects about them that made each different from the others in the study. Practice one, for example, was small and overcrowded but gave an impression of being a friendly work place. It also had a large number of South Asian (GP) staff in comparison to the other two Practices. The following extract from my reflexive diary highlights my initial thoughts about this practice:

“This was the first time that I had been to the Practice and found it to be a very small practice, built on a very small piece of land within [name of city] itself”

(EXTRACT FROM REFLEXIVE DIARY)

Practice two was medium sized and had an impression of openness, professionalism and efficiency. Finally Practice three was the largest practice in the study and bigger than other Practices I had visited previously. Again, the following extract from the reflexive diary I kept describes my initial thoughts regarding this Practice:

“The Centre seems very large and has two parts to it: one being the regular GP Practice and the other seemed to be what I can only describe as a small out-patients centre. This unit had its own reception area and I sensed there to be a difference in the status of the receptionists here. I have arranged to spend a couple of hours on the reception desk there next week”

(EXTRACT FROM REFLEXIVE DIARY)

My initial visits also enabled me to identify what interprofessional meetings took place at each of the Practices in order for me to select formal CP activities that I might later chose to observe. Where possible I noted the dates of these meetings and negotiated to attend as an observer.

I have provided a floor plan of each of the Practices in Appendix One in order to help provide a visual appreciation of each of the Practices used in the study. However, to ensure anonymity is maintained, I have limited the detail provided.

Data Collection Methods

Observations

Traditionally data gathering in qualitative studies is a journey whereby understanding develops as new discoveries are made and verified in ways which enable validation of the evidence collected to occur (Angrosino & Mays de Perès, 2003, Sarantakos, 2013). In critical ethnography the researcher begins by familiarizing themselves with the research field in order to gain understanding of its culture and the context within which the participants act. Familiarity with the field then enables them to identify better the types of questions they will ask when interviewing participants (Madison, 2012).

As I stated above I had completed another research study involving six GP Practices and their staff shortly prior to undertaking this study. In doing so I had already gained insight into the local culture of the GP Practices and therefore believed that I could move more quickly to interviewing the staff teams. The exception to this was Practice Three which, as I stated above, was much larger than I had experienced previously and as such I arranged to spend some time at the reception desk of this Practice to gain a better understanding of how it functioned.

The distinction between 'participatory' and 'non-participatory' observation has now also been called into question as the degree of participation is likely to be more fluid than traditional methods with the level of engagement of the researcher altering throughout the study depending on what is taking place at any given time. It is now believed to be more appropriate to consider observational techniques in terms of degrees of participation rather than discreetly fitting into a specific category (Angrosino & Mays de Pères, 2003).

Due to the nature of the field I was entering I deemed full participation, or immersion, into the field under study impractical (Holmes & Marcus, 2005; Tedlock, 2005). Much of the work carried out by the professions involved one-to-one patient activities which would have been ethically inappropriate to observe given the aims of this

study (Moore, 2012). Furthermore, the DNs and HVs' one-to-one activities involved them being off-site for significant parts of the day which would have increased the size of the field (and the impracticality of undertaking participatory observations) being studied still further (Holmes & Marcus, 2005; Tedlock, 2005).

Equally I felt that statements suggesting the research can be completely non-participatory were likely to be unrealistic as this denies that the researcher's presence can influence the field under studying (Fontana & Frey, 2005). Furthermore, as I argued earlier, contemporary qualitative research and critical ethnography in particular embraces subjectivity and recognizes that no interaction with a field can be neutral (Foley & Valenzuela, 2005; Fontana & Frey, 2005). Objectivity, therefore, is no longer considered an appropriate goal of qualitative research (Angrosino, 2005). I recognized, however, that the observations I undertook needed to be sympathetic to the sensitive and confidential nature of the work carried-out whilst appreciating my presence and the inevitable impact this would have on the field I was studying (Moore, 2012).

Pre-study decisions regarding level of participation will also often alter once the researcher is in the field due to the often unpredictable occurrences that can take place (Angrosino & Mays de Pères, 2003) and this was also found to be the case in my study. For example, whilst I interacted with the staff team during my first observation of Practice Three, as I identified above, I took the decision to attempt to be unobtrusive as an observer at the formal activities I observed. The meetings involved formal sharing of information regarding patients' health care needs and as such I deemed it inappropriate to engage. However whilst observing one such meeting at Practice Two the meeting was interrupted when a loud crash was heard from immediately outside of the Practice. During this unexpected interruption one of the doctors came over to me and began a conversation as to how he believed humour helped them cope with some of their experiences. Being approached during observations of a formal meeting such as this was not an isolated event during the study and reminded me of the need to be flexible as to the level of observation undertaken and to appreciate my subjective presence within the field (Angrosino & Mays de Pères, 2003).

My level of engagement did alter during this study depending on what I was observing and the behaviours of the participants. As in the example above, whilst I had chosen one level of (dis)engagement, one of the participants clearly felt the need to justify further to me what was happening and therefore interact with me. Although my own theoretical perspective meant that I saw the GP as part of the dominating group I

was aiming to question, I was equally aware of my own powerful position as a researcher and the need to ensure I supported all participants to have a voice (Creswell, 2013). Equally my desire to gain rich data meant that it was essential that I gave all participants a voice (Madison, 2012).

Focus Groups

As I stated earlier, a decision was made to carry out focus groups as the main data collection method for this study. Arrangements for these were made during the preliminary discussions with the PMs and that the staff focus groups (and later the medical student focus groups) would be coordinated by themselves. Table Two identifies the focus groups and individual interviews that I undertook along with numbers of participants present at each.

Table 2 Identifying numbers of focus groups and in-depth interviews across professions and practices

Professional Groups	Practice One		Practice Two		Practice Three		Total Number of Focus Groups by Profession	Total Number of Participants by Profession
	Number of Focus Groups	Number of Participants	Number of Focus groups	Number of Participants	Number of Focus Groups	Number of Participants	Number of Focus Groups	Number of Participants
Administrators	1	9	1	6	1	9	3	24
District Nurses	1	6	1	3	1	5	3	14
GPs	1	6*	2	2 + 2*	1	5	4	15
Health Visitors	1	1**	0	0	1	4	2	5
Practice Nurses	1	6	0	0	0	0	1	6
Medical Students	0	0	1	3	1	5	2	8
Nursing Students	1	1**	1	3	1	3	3	7
Overall Total:	6	29	6	19	6	31	18	79

* Indicates inclusion of nurse practitioner

** Indicates in-depth interviews

Decisions regarding the composition of the group need to be made in order to take into consideration the aim of the focus groups itself (Fern, 2001). In this study I took the decision to interview participants in uni-professional groups. In this way I hoped I could attain theoretical explanations as to the opinions of those from a shared population, and in particular in relation to their social position to others (professions) (Fern 2001). Furthermore, as discussed earlier in this chapter, Bourdieu (2006) argues that there is no such thing as socially neutral space and that individuals will continually categorize, subconsciously, individuals resulting in natural 'groups' transpiring (Bourdieu, 1989). Mixing professions within the groups, therefore, could have introduced issues of hierarchy and a power imbalance which may have affected participants' ability to have a voice as required (Creswell, 2007; Guba & Lincoln, 2005; Macnaghten & Myers, 2007). For this reason I felt it to be most appropriate to carry out the focus groups uni-professionally. This would also, I hoped, enable me to gain an appreciation of how the different professions each considered they interacted with the field, without their feeling inhibited by the presence of others from outside of their 'natural' group (Bourdieu, 1979; Macnaghten & Myers, 2007). Equally perceptions of what took place could then be explored further with others who shared similar experiences (the same uni-professional groups but at different Practices as well as different professional groups from within the same Practices) thus providing additional data that I may otherwise not have received (Guba and Lincoln, 2005).

I recognized, however, that some decisions I made would close off other options (Macnaghten & Myers, 2007). My decision to undertake focus groups homogametically, for example, meant that I would not be able to observe interprofessional interactions in a focus groups setting. It also influenced the number of focus groups I was able to carry out. For example despite ongoing attempts to carry out focus groups with each profession at all three of the Practices, I was unable to achieve this. Lack of availability of staff, with regards to the PNs at two of the Practices, and a lack of willingness to be interviewed, with regards to the HVs at one of the Practices, meant that I was not able to include them in the focus groups I completed. However, as I identified above, the aim of this study was to explore the culture of the field and as such I was not attempting to achieve representativeness (Baszanger & Dodier, 2004; Creswell, 2007). Instead I was aiming to provide a detailed account of the group under study, which I hoped to attain by gathering data through differing means (Creswell, 2007) and achieve a multi-dimensional layer of findings through a rich array of data (Denzin & Lincoln, 2005; Richardson & Adams St. Pierre, 2005).

My decision to undertake focus groups in homogametic groups not only impacted on the number of focus groups I could undertake, but also on the group size as the limited numbers of professions ultimately restricted the numbers available to participate. This was

further restricted by the choice to interview participants in their own work place. There appears to be a lack of consensus as to the 'ideal' number for a focus group. Macnaghten and Myers (2007) for example, suggest it should be between four and eight, whereas Green and Browne (2005) advise it should be between eight and twelve. However I felt that providing participants with the opportunity to discuss issues from their own social position with the support of others from this same position out-weighed the limitations that potentially small focus groups numbers would bring (Macnaghten & Myers, 2007). In addition, due to there being just one nursing student who had been on placement at one of the Practices (Practice One) in the time period set (which I discuss further below), I took the decision to interview this student alone. Furthermore limited numbers of staff available on some occasions also resulted in one participant being interviewed alone and others ($n = 2 \times 2$) in pairs. Limited numbers of participants can alter the type of data received. Lone interviews, for example, provide the researcher with a single account of their experience rather than a rich collation of beliefs and possible disagreements (Brown, 1999). However, as I will discuss later in this chapter as well as in the following chapter, these limited numbers enabled me to gain insights into what was happening which may otherwise have been lost.

Any type of research is time limited. The timing of a qualitative study, however, is an important consideration particularly when involving medical and nursing students who are only on placement in those settings for set periods of time (Mackenzie, 1994). Therefore, the timing of the study will influence the availability of important informants and influence the validity of the study (Mackenzie, 1994). The need to obtain ethical approval, however, equally influences when the study can be carried out. In the case of this study, the time of year (springtime) that ethical approval was obtained meant that there was only a finite period of time to interview the medical students prior to their completing their (four week) placements which were immediately followed by their final exams. Due to the length of the placements I felt it was important to interview the students towards the end of their placement in order to maximize the time they had been immersed in the placement setting. Furthermore, with the next groups of students not due to commence placements in this setting until the autumn, the time available was therefore limited. In fact these time limitations did impact on the availability of the students at Practice One where, despite efforts to access them, I found it was not possible to interview this group of students.

Nursing students, as I identified earlier, were limited to just one or two students on placement in the GP Practices at any given time. Furthermore, at the time of data collection, no nursing students were on placement in the study Practices. For this reason I made the decision to access students who had been on placement at any of the Practices involved in the study over the previous twelve month period. Whilst student numbers remained limited ($n =$

seven), the numbers were similar to that of the medical students ($n = eight$) who were on placement at the time of the study and available to participate in the focus groups. Whilst the medical students were all final (fifth) year students, the nursing students were both first and final (third) year students and had been on placement at any one of the three GP Practices. Therefore whilst limited in number the selection of students available represented both professions, all three Practices and, a range of level of experience and therefore potential richness of data.

As with the staff from the GP Practices I had no previous relationship with any of these students and as such considered the information provided via an Information Sheet and Consent Form to be sufficient to ensure their participation was voluntary and ethical (Moore, 2012). In addition, as I identified previously, these students came from the university to which I had personal affiliation and recognized that there maybe future contact with these students. For this reason I felt it important to take additional measures to ensure: they did not feel obliged to participate in the study; that they were assured of their anonymity and; both their ability to withdraw their consent to participate or use information provided was clear (Chell, 1998). To this end, I contacted the nursing students in the first instance via email in order to increase distance and reduce potential feelings of coercion (Christians, 2005). In addition, they were asked to sign their consent forms in front of a witness ahead of the focus groups or interview itself in order to allow a cooling-off period and thus reduce further any potential pressure to participate that the students may have felt (Christians, 2005). Finally, as with all focus groups undertaken, I gave assurances that any direct quotes used in papers which would be in the public domain would be anonymized in order to ensure they could not be traced back to any specific participant (Chell, 1998).

Having an affiliation with participants involved in any sort of qualitative study is becoming common place (Holmes & Marcus, 2005; Moore, 2012) as researchers frequently have, at a minimum, an appreciation of the field they are studying. Most commonly in health and social studies, however, the field under study is their own area of practice (Holmes & Marcus, 2005; Moore, 2012) creating a blurring of roles and identities (Allen, 2004; Coghlan & Casey, 2001). In this study my identity as a previous nurse and current nurse lecturer was reconciled through the position I took as a critical ethnographer focusing on the power-relationships including the hegemony and authority in doctor-nurse CP (Creswell, 2007; Lincoln, 2005). As such I felt my focus on practice from the perspective of a nurse lecturer was justified (Coghlan & Casey, 2001; Giampapa, 2011). In this study there was also a blurring of positions whereby the affiliation with the field altered depending on what, or who, I was studying (Moore, 2012; Ritchie et al., 2009). My undertaking of a previous study, for example, also involved staff from GP Practices which had provided me with a level of

understanding into the workings of GP Practices prior to the commencement of the study alongside an appreciation of linguistic coding used (Allen, 2004). My professional background as a nurse also created a shared identity and therefore greater allegiance with the nursing staff and my role of lecturer in nursing an even greater allegiance with the student nurses. As the study evolved there became an increased risk that the level of affiliation with the field would increase creating a risk of going 'native' as emersion into and understanding of the field as a whole rose (Moore, 2012).

This affiliation with the field under study is commonly described as 'insider research' (Allen, 2004; Moore, 2012). From the researcher's perspective this can be challenging as greater affiliation with a particular group can reduce the ability to recognize taken-for-granted behaviours (Bonner & Tolhurst, 2002; Edvaardner & Street, 2007; Holmes & Marcus, 2005). As insider research has become commonplace reflexive practice has immerged as a means of enhancing validity in the research process (Foley & Valenzuela, 2005). I discuss the use of reflexivity later in this chapter and use extracts from the reflexive diary I kept both in this and the following two chapters. I do so both as a means of demonstrating the journey taken in gaining understanding (Foley & Valenzuela, 2005) and in an attempt to provide multi-faceted accounts of what was happening in the field (Richardson & Adams St. Pierre, 2005) and make explicit the rigour, and therefore ethical positionality, of myself as the researcher (Coghlan & Casey, 2001).

Data Collection

Contemporary use of Focus Groups

The framework within which focus groups are used will influence how they are implemented and the types of questions asked (Fontana & Frey, 2005). Both the use of critical ethnography and Bourdieu's theory of social life (1979) helped me to focus my questioning to issues related to power relationships in relation to the overall aims of the study (Kamberelis & Dimitriadis, 2005; Macnaghten and Myers, 2007). For example, including specific questions in the interview schedule regarding how well they believed the different professions worked together in their particular Practice. I will discuss, in-depth, the issues related to this in the following two chapters.

I used focus groups as the main data-collecting tool and therefore included specific questions which aimed at eliciting information relating to the participants' day to day activities and patterns of behaviour (Creswell, 2007; Madison, 2012). For example one of the first questions I asked in each of the focus groups was 'tell me what a normal day looks like to

you?’ my aim for which was to gain an appreciation of the day to day activities from the different participants’ perspectives.

Using focus groups also provided me with opportunities to examine the interaction and behaviours of group members (Fern, 2001) including the way in which participants spoke rather than simply focusing on what it is that they were saying (Fontana & Frey, 2003). For example comments made during a focus group interview are not always acted out in behaviours the researcher may go on to observe (Fern, 2001). As such the focus group is multi-dimensional allowing the group dynamics to be explored rather than simply recording what is being said (Fontana & Frey, 2005) as the following extract from my reflexive diary shows:

“During the interview with the DNs I was struck as to how much they seemed to work in isolation to the rest of the Practice, despite being based in the same building. I am looking forward to reading the transcript of this focus group interview in particular. Whilst most were quiet and left it to a small number to respond, I did feel that the responses I received were open and honest”.

(EXTRACT FROM REFLEXIVE DIARY)

Whilst some decisions as to what can be asked, how it can be asked, and at what point are controlled by the researcher others are dictated by those being interviewed. As identified above contemporary use of focus groups commonly calls for the interviewer to play an active, rather than neutral, role in the interview process: getting to know and engaging with, their participants in order to collect data that is rich in texture (Brown, 1999; Fontana & Frey, 2005). I believed I achieved this in this study to various degrees in the different focus groups. However one of the first focus groups I undertook was carried out with a group of GPs at Practice Two. Although they had originally agreed to participate in a 30 minute focus group their previous meeting had over-ran leaving just 15 minutes for the focus group to take place. This removed the opportunity to begin by getting to know the participants before attempting to discuss more serious issues (Fontana & Frey, 2005). Therefore the interview remained formal with requests for candor denied (Brown, 1999). At one point during this focus group for example, one of the GPs disclosed a problematic relationship with the midwifery service. However, whilst I made attempts to get this GP to discuss this further this was met with a firm refusal as the following extract from the focus group shows:

“M: (...) we cannot, for love nor money, we can’t get (the midwives) involved

Me: (...) why is that do you think?

M I think there maybe a political agenda there which we haven't been able to deal with. I think it's not the individual midwives who are great I think there is a political agenda about midwifery in general practice which we can't get to grips with.

Me: I don't know what this political agenda is

M: I don't think it's worth speculating while we're being recorded"
(FOCUS GROUP INTERVIEW WITH GPS, PRACTICE TWO)

Whilst it is important for the researcher to direct the focus group and encourage dialogue (Fern, 2001) I failed to achieve it in this early focus group. As I argued in chapter one and summarized above the doctor-nurse relationship is considered to be hierarchical in nature with the doctor holding the dominant position (For example: Charles-Jones et al., 2003; Coombs & Ersser, 2004). This historical relationship appeared also to be evident within this focus group between myself and the GPs which I was unable to overcome within the time constraints imposed.

Although it would be naive of me to consider this power imbalance could have been redressed solely through longer time spent in the focus group (Fontana & Frey, 2005), it did appear to play a role which was less evident in other focus groups which were longer (30 minutes – one hour) in length where time for relationship-building was available (Fontana & Frey, 2005). In a subsequent focus group with a different group of GPs, for example, an entire afternoon had been set aside by the PM for me to carry out three focus groups. On this occasion the GPs were actually waiting for another focus group to be completed and appeared in no rush to complete their own interview once it commenced. I was therefore able to spend time carrying out initial formalities before moving on to ask more probing questions (Madison, 2012). In this later focus group I found responses to be interspersed with humour and laughter which suggested to me that they were active participants in the focus group, rather than providers of carefully selected information (Fontana & Frey, 2003) as the following extract from my reflexive diary kept shows:

"Whilst talking to the trainee GP another member of the group passed him an envelope with a short message on it. The trainee immediately looked down at his lap. The other GP remained stony faced throughout. After they had all left I noticed that the envelope had been left on the table and saw that what had been written was the following: 'are your flies open?'"

(EXTRACT FROM REFLEXIVE DIARY)

Whatever the aim of the focus group a key element involves the skill of the researcher in listening to the participants in order to discover patterns and identify the issues they (the participants) select to discuss (or omit) and why (Gilchrist & Williams, 1999). How an issue is discussed and responded to, for example, can tell the researcher as much about the issues being explored as the responses to specific questioning (Huberman & Miles, 1998). For example, whilst the GP described above had been reluctant to discuss issues regarding themselves and the midwifery service, what was still evident was that they believed there remained problems with the relationship between the two professions. In identifying this, it then triggered me to include an additional question in later focus groups which specifically asked them to discuss their relationship with this profession as the example from a later focus group illustrates:

“Me: What I’ve picked up from other GP practices is that the midwifery service works very differently and I wondered what your relationship here was with the midwifery team?”

(EXTRACT FROM FOCUS GROUP INTERVIEW WITH GPs AT PRACTICE THREE)

The Reflexive Process

A frequently used method to facilitating reflexivity is the keeping of a reflexive diary (Foley & Valenzuela, 2005). As previous examples I included in this chapter have shown, this enables the researcher to record and provide evidence as to how the study was executed and the personal processes undertaken in order to attain the findings reached: thereby providing transparency of the research process as a whole (Allen, 2004).

Considered as an essential tool in qualitative research the reflexive process is, however, much more than simply a means of providing evidence. It is also an integral, multi-faceted, part of the research process and is used by the researcher throughout in order to facilitate self-awareness and cultural awareness of those being studied in order to achieve meaning. As such it is simultaneously both a means of data collection and of analysis (Alexander, 2005; Foley & Valenzuela, 2005).

With this in mind I began to keep a reflexive diary from the outset and both wrote in it and re-read it regularly throughout the study in order to help elicit meaning as well as identify issues for further exploration. For example as I completed focus groups I was able to identify specific issues which then enabled me to create tentative hypothesis' which I was able to use in order to explore within both later focus groups and through observations made

(Mackenzie, 1994). Thus, in relation to the first (short) focus group with the GPs I was still able to elicit a significant amount of information that I could use for future exploration. One example of this related to the significance they placed on the physical space and the positive influence being based in the same building had on interprofessional relationships as the following extract shows:

“Like the administrators two weeks previously, the GPs were quick to say that they had good relationships with the DNs and HVs and felt this to be because they were based in the building and worked only with their patients. However, when asked if they felt that the midwives being based elsewhere was the reason there was not such good relationships, they were vague and one went so far as to say that he would not give me the answer to this whilst the tape recorder was running”

(EXTRACT FROM REFLEXIVE DIARY)

In this example a connection was made between what had been said in one focus group and what was also said in another. This then led me to also explore this concept in later focus groups (Mackenzie, 1994).

It also helped me identify questions I wanted to ask. One such example related to the identification of a question I wanted to explore with the medical students following the completion of a focus group with a set of administrators at Practice One as the following extract from my Reflexive Diary demonstrates:

“[The administrators] also confirmed that the student nurses when placed with the District Nursing team generally spent a half day with them [i.e. Receptionists], watching them do their job. The medical students do not. Why is this I wonder? Is it because it is seen as more important for nurses to know about the role of the Receptionist? I cannot think that this would be the case. GPs liaise with the Receptionists on a daily basis, they informed me, so why don't medical students get the opportunity to see what their role entails?”

(EXTRACT FROM REFLEXIVE DIARY)

My analysis of data therefore took place through a series of layers (Denzin & Lincoln, 2005; Richardson & Adams St. Pierre, 2005). It also took place whilst the data was still being collected in order for hypothesis' to be created which were then tentatively tested, re-examined and revised throughout the data collection and analytical process (Denzin & Lincoln, 2005; Huberman & Miles, 1998). For example, as well as including an additional question regarding relationships with midwives in my interview schedule, I was also able to identify that the midwives were not based at the GP Practices but worked on a 'patch' basis which covered

a number of GP Practices and the women registered at them. This meant that they only visited individual GP Practices on set days each week. Furthermore whilst the HVs and DNs worked for the local Primary Care Trust the midwives were employed by a local Acute Care Trust. On recording this in my reflexive diary I also made the following comment:

"I am beginning to see that the organizational barriers to midwives engaging in interprofessional working are even greater than for the DNs and HVs"

(EXTRACT FROM REFLEXIVE DIARY)

Reflexive diaries can also be used as a means of identifying activities for observation (Gilchrist & Williams, 1999; Kamberelis & Dimitriadis, 2005). In the example below, for example, I used it to identify the specific, formal, interprofessional monthly meetings that took place at one of the Practices that I was then able to arrange to observe. This had come to light during one of the first of the focus groups which was then recorded in the reflexive diary as a useful meeting to observe as the following extract shows:

"It maybe useful to sit in on the clinical, interprofessional, meeting that they spoke of to see the dynamics within the team".

(EXTRACT FROM REFLEXIVE DIARY)

Therefore, rather than simply reporting what was viewed in the field, the use of a reflexive process enables the researcher to explore the facts (the first order concepts) through various layers of interpretation, in order to make sense of the data (Denzin & Lincoln, 2005): thus enabling me to examine, re-examine and revise subsequent themes in an analytical manner (Huberman & Miles, 1998).

The keeping of a reflexive diary, as I have demonstrated here, helps provide an audit trail to aid credibility of the final findings produced (Avis, 2005; Green & Thorogood, 2004) which is consistent with the methodological stance of the researcher (Green & Thorogood, 2004). Furthermore, as I attempt to demonstrate below, it can also be used as part of a structured framework which facilitates a systematic yet dynamic process to the analysis of the data as a whole.

Template Analysis

The method I used for the process of identifying and organizing themes in my study was template analysis. Template analysis theoretically occupies a position between the prescriptive - deductive approach of content analysis and the totally inductive approach of

grounded theory (King, 1998; Ryan & Bernard, 2003). I chose template analysis in part because it is a generic style of thematic analysis which can be adapted to the philosophical and theoretical position of a particular study. I also believed its flexible structure would aid my developing understanding in a non-prescriptive manner: particularly as it was recommended as a useful means of coding large sections of text (King, 1998; 2004).

In template analysis a coding framework (the "template") is created by first developing a set of codes 'a priori' which are revisited and revised throughout the analytical process (Waring & Wainwright, 2008). Additional codes are also created and refined throughout in order to create a hierarchical structure (King, 1998). This continues in a five stage process as follows:

- 1) Describing
- 2) Organising
- 3) Connecting
- 4) Corroborating/legitimizing
- 5) Representing the account

These stages are passed through in a spiral, rather than linear, manner with the researcher returning to earlier codes to revise and review as further reading and analysis provides deeper insight (Crabtree & Miller, 1999).

Development of the initial template commonly takes place through engagement with the literature and an initial sub-set of the data (King, 1998; 2004). Care should be taken not to make the initial template too extensive as this may blinker the researcher in their consideration of subsequent data. For this study I used the focus group topic areas as a means of achieving this. I read through each of my interview schedules and highlighted the interview questions in bold ensuring all text was included. To aid the coding process I then shortened each of the questions into a simple statement which reflected the original question. Therefore the original question: 'tell me what a normal day looks like to you' became 'a normal day' and 'what about if you have a student with you?' became 'a normal day with students' ensuring that I kept a flavour of the original description (King, 1998). However whilst apparently straight-forward, as I stated earlier, in qualitative research it is common (and appropriate) for the interview schedule to be revised as new discoveries are made and lines of

inquiry added (Fontana & Frey, 2005) which did indeed take place in this study. Therefore where I had altered questions I compared them to previous schedules and where possible broadened them out to include wider sections of text. Where this was not possible, and in particular as later schedules were added to the template, I created additional codes. Table Three below shows the initial template that was created to which I initially allocated all my text.

Table 3 Top Level Codes to which all Interview Transcripts were categorized

A normal day
Factors affecting collaborative practice
Collaborative practice skills
Contact with other professionals
Student activities
Student contact with other professionals
Interprofessional learning participation
Effective collaborative practice
Suggestions to improve collaborative practice
Enhancing learning
Earning respect
Conflict skills

The use of a software package to aid the analytical process is now common practice. However reading and highlighting key issues on the original transcript itself to identify themes is also possible (King, 2004). In this study I used both methods interchangeably with the software package NVIVO8 being the package of choice used. Once the initial template is created lower level codes are added to enable fine distinctions and connections to be made (King, 1998). I found the most readily achievable way of doing this was by reading and re-reading the individual paper transcripts and highlighting the text considered to be relevant. These then enabled me to cluster them together using NVIVO8 to create a lower level code whereby each piece of relevant text could be filed together. Thus I was able to expand upon and revise the themes as new insights were made (King, 1998).

Initially the lower level codes I created were taken from readily identifiable elements of the texts. One such example of this was the difficulties with the midwifery service, discussed above, which were raised by one set of GPs in an early focus group. Whilst a top-order (and therefore broad) code had been added to identify issues of conflict itself, by identifying all the text relating specifically to midwifery these could be collated together and

included under a discreet lower level code named specifically 'midwives'. The same was true of text relating to the use of physical space. As I also highlighted above, when asked how well the different professions worked together in each Practice, a common response I received had been that they all worked very well together and the reason for this was their physical proximity. However, I was able to identify the level of contact between the different groups of professionals by reading the transcripts and identifying who had had contact with whom. In doing so I created a series of sociograms of each professional group at each Practice identifying who had initiated the contact and whether the contact was face-to-face. Creating the sociograms helped me establish the level of contact between each of the teams. In particular it demonstrated that the level of contact initiated by other professions towards GPs, for example, was low. However GPs seemed to have a reasonable level of contact with the administrators, although this tended to be initiated by them. In this way I was able to make connections between how physical space was used either as a barrier to interaction or, to facilitate it. I have included a selection of the sociograms that I created in figure one below. I also discuss these further in the following chapter. Table Four immediately below this shows the initial lower level codes that I identified.

Figure 1: Sociograms illustrating Interactions between Different Professions

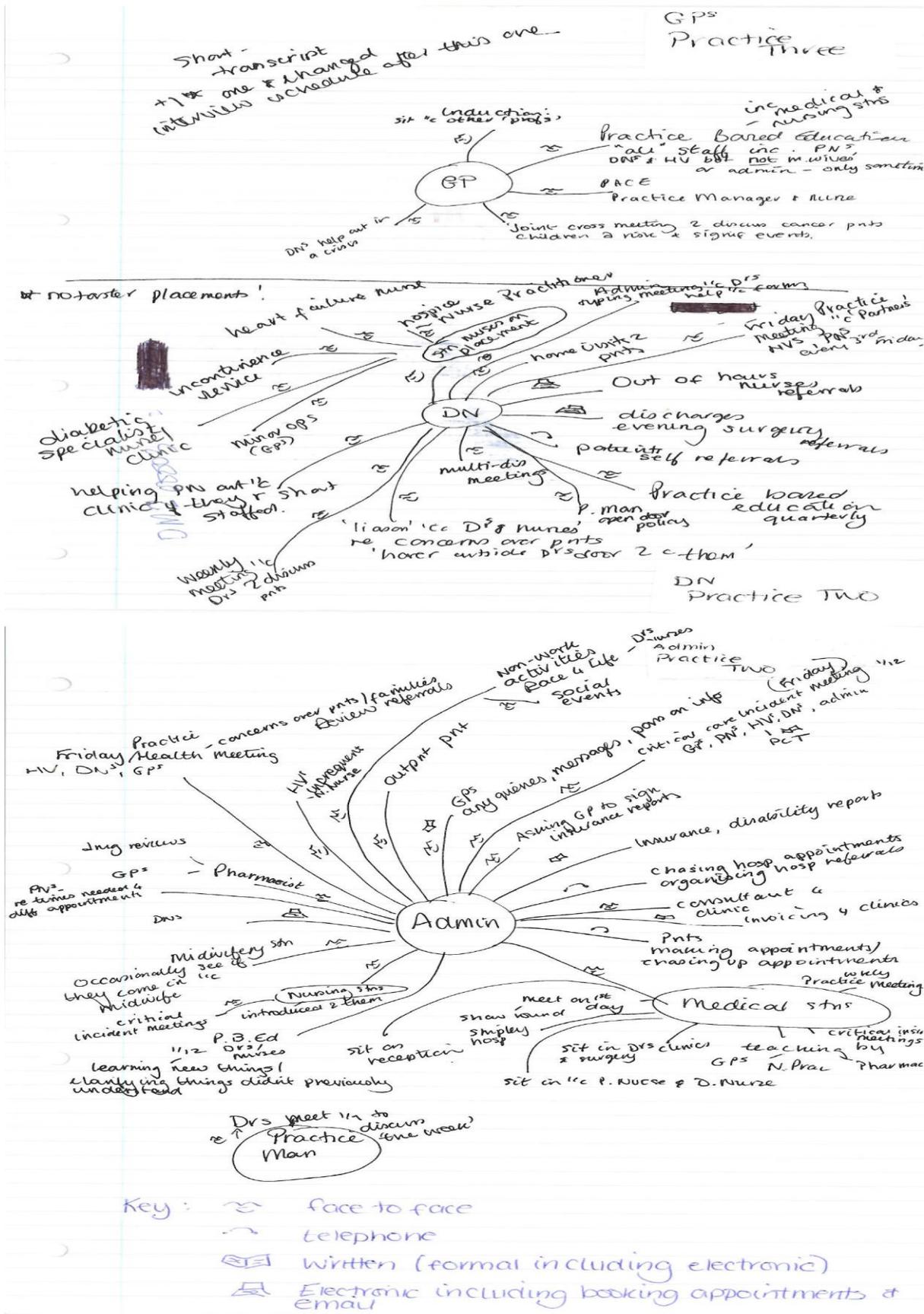


Table 4 Lower Level Codes Initially Identified

Physical distance
General conflict skills
Uni-professional conflict skills
Midwives
Organization of student activities

The decision to add or alter codes after the initial creation lies with the researcher but when modifications are made, these should occur as reading and interpreting of the texts takes place (Crabtree & Miller, 1999; King, 2004). Normally, modifications made fall into one of four categories as follows:

- Insertion: whereby new codes are added
- Deletion: whereby codes are removed
- Changing Scope: whereby the hierarchical order of codes within a cluster is changed and;
- Changing Higher-order Classification: whereby codes are moved from one cluster to another.

(King, 1998; 2004)

Insertion of new codes is generally the most common modification that is made (King, 1998). In my study this occurred regularly throughout the analytical process: not only in relation to lower-level codes as I identified above, but also in relation to top-level codes. This happened particularly because the focus groups with the students took place after the other focus groups had all been completed: by which time I had already created an initial template. Because of this I added new top-level codes at the end of the interviews with both the medical and the nursing students as I made new insights. Table Five below identifies the top-level codes that I added following completion of these later focus groups.

Table 5 Top-level Codes added to the Template following Completion of the Student Focus Groups

Top-level Codes added following transcription of medical students' focus groups: Factors affecting collaborative practice Top-level Codes added following transcription of student nurses: Conflict skills Enhancing learning Earning respect
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As can be seen from the names of these codes they did not, necessarily, relate specifically to the student experience per se. However, I had continued to read and re-read my existing transcripts and therefore continued to make new insights throughout the data collecting process (King, 2004).

One code that was added specifically that did relate to the learning experience however was the 'enhancing learning' code. Having interviewed the medical students I was struck by how much their learning was focused on their final exams rather than the learning experiences offered from the placement environment itself as the extract from my reflexive diary shows:

"It was interesting to note that the fifth year students spent their placement preparing for their final exams. In this respect they could have been placed anywhere. Third year students spent time with other professional groups however and this does raise the question as to whether interprofessional working is seen as a lower level skill or not. Perhaps I am just being unfair as any student approaching their finals would want to concentrate just on this but it will be interesting see the differences between these and other student groups"
(EXTRACT FROM REFLEXIVE DIARY)

I carried on making revisions to the higher-order codes as I continued through the analytical process. As I highlighted earlier, making revisions to the interview schedule during the progress of the study meant that it was not immediately possible for me to identify pieces of text to allocate to the initial codes I had created. In refining these codes it later became apparent that the codes specifically relating to collaborative practice overlapped each other. Therefore, these were revised and the texts originally collated within each of these codes pooled together under one new heading of 'factors affecting collaborative practice' as identified in Table Five above.

Reading and re-reading the transcripts and the initial codes I had identified aided the process of making new insights and enabled me to make further revisions (King, 1998). As noted, the first higher-level codes that I created were based on sections of the text that I considered to be readily identifiable and were therefore descriptive in nature. However codes created should relate to the theoretical model within which the study has taken place, which should be cross-referenced to the project aims (King, 1998). With this in mind I used Bourdieu's theory of social life (1979) in order to gain a deeper appreciation of what was taking place in relation to the aims of my study. In doing so I created further lower-level codes. For example, as I identified earlier, Bourdieu describes capital in terms of both quantity and weight, being both objectified and embodied and what one agent holds in relation to another (Bourdieu, 1985; 1989; 1996). In considering this I added an initial lower-level code to the high-level one: 'factors affecting interprofessional working', which I simply called 'capital'. I then re-examined each transcript and included anything within this code that I considered could be used as capital. For example I particularly found the discussions relating to physical space to be significant here. Therefore I moved the original lower-level code 'physical distance' to form a third-level code under this heading.

As further analysis took place I recognized that physical space also played a significant role in relation to how the different professions collaborated at every level and as such was inextricably linked to all codes identified in different ways. Codes are linked together in a linear manner as levels of hierarchy are identified although the same lower-level code can be applied under separate high-level themes (King, 1998). However, I found that the influence of physical space in this study had greater or lesser significance depending on the theme identified. For example, I believed that the physical space occupied was influenced by the volume and weight of capital held. This in turn influenced the level of accessibility to themselves, by others. Changing the higher-order classification is a recognized way of refining the template (King, 1998; 2004) and I used it in this study as I gained a deeper insight into what was happening.

In doing this I took the decision to merge all the top-level codes relating to collaborative practice and re-divide them again with differing foci and levels of emphasis on physical space. For example, one new top-level code was named 'The Social and Physical Space Relationship'. Another was entitled: 'Social Positions and Collaborative Practice'. In this example, 'Capital' was identified as a second-level code, with 'accessibility and physical distance' created (among others) as a third-level code below this. However, in another example again, the influence of physical space was considered to have a broader, more general, influence on collaborative practice and in this example was linked to collaborative practice to form a new top-level code entitled 'Physical Space and Collaborative Practice'.

However, physical distance was considered to be a separate (second-order) theme and was therefore identified as a code in its own right as follows: 'Physical Space and Collaborative Practice' > 'Physical Distance'. A list reflecting the final template is provided in Table Six below. I discuss how the codes related to each other and the content of each of the final themes in detail in the following chapters.

Table 6: The Final Template

Physical Space and Collaborative Practice
Physical Distance
Relationships
Midwives
Making an Effort to Engage
Physical Distance
Game Playing
Rules
The Social and Physical Space Relationship
Capital
Accessibility
Conforming
Routines
Social Positions and Collaborative Practice
Capital
NPs
Midwives
Game Playing
Titles
Accessibility and Physical Space
Linguistics
The Construction of the Student Learning Experience
Group Affiliation
Collaborative Practice
Timing
Gender
Conflict
The Culture of the Learning Experience
Construction of the Day

<p>Knowing one's Place</p> <p>Autonomy</p> <p>The Social Position within the Team</p> <p>Acknowledging Hierarchy</p>
--

Developing the final interpretation

Developing the coding template and its constituent themes is an interpretative act, but only the start of the process. To take it further, I used a number of strategies. Keeping a reflexive diary was a central strategy that I used in order to both help make sense of the data and illustrate the multiple understandings that emerged from the data (Foley & Valenzuela, 2005). Another strategy I used was that of 'listing' (i.e. mapping which themes occur in which transcripts; King, 1998). I used this strategy early in the analytical process in order to identify issues for further exploration. For example when searching for text that related to the code 'capital' I noticed that the NP in one of the interviews appeared to be using her own capital in an attempt to achieve equal social standing with that of the GP. However I was also aware that the high occurrence of a code does not necessarily mean that it is significant (King, 1998). What it did do, however, was allow me to make an early, tentative, hypothesis as to what was happening. Having identified a number of occasions whereby the NP appeared to be attempting to associate herself as a social equal with the GP I then used Bourdieu's theory of social life (Bourdieu, 1979) in order to explore what was happening further. The following extract from my reflexive diary describes the process and the insights I made:

"In reading Bourdieu's theory on capital I noticed, with particular interest, the position that the NPs took within the Practice. In interviewing the staff uni-professionally I had failed to group the NPs into any one category. This led them to place themselves in the focus group of their choice. In doing so they chose to attend the focus group with the GPs, rather than with their nursing colleagues. At Practice One the GPs were all interviewed as one group but the NP chose to attend with them. At Practice Two the focus groups with the 'GPs' were coordinated (by them) into two pairs. The second 'pair' turned out to be a GP and a NP. Whilst it was difficult to identify the NP specifically in the transcription of the interview at Practice One due to the number of people present, this was not the case with the transcript from Practice Two. In this latter interview the GP and the NP were each of a different gender, making it possible to identify who was speaking. In re-reading this second transcript it became apparent that each had different ways of interacting with each other. The NP for example, looked for ways to affiliate herself with the GP, whilst this behaviour was not reciprocated by the GP. At the start,

for example, each was asked to describe their normal day and in doing so the NP described it as follows:

"I don't do home visits, which is the main difference between me and the GPs here ..."
(PRACTICE TWO: NP)

Once I recognized this I read through the transcript again specifically looking for examples of things the NP had said which appeared to reconcile her with the GPs rather than the PNs. In doing so these were added to the tree-codes: 'Social positions and Collaborative Practice' > 'Capital' > 'NP'.

(EXTRACT FROM REFLEXIVE DIARY)

I found the listing of the frequency as to how often the NP attempted to affiliate herself to the GP to be a useful way of initially identifying issues. However using a reflexive approach then enabled me to explore this at a deeper level (Allen, 2004; King 1998; 2004) in order to reject or corroborate the initial interpretations I had made (Crabtree & Miller, 1999). In particular, I had already identified having a private consulting room as a form of capital (Bourdieu, 1985; 1989; 1996) yet also found that this appeared insufficient capital to place the NP on equal standing with the GPs. I had also identified the private consulting room as a means of restricting access to the GPs but did not believe it to be the case in relation to the NPs. In creating a linear thread of codes therefore, 'Accessibility and Physical Distance' was identified as a lower-order code below 'Capital', but on a level with, rather than associated with, the code 'NP'.

A further example of an initial list I made related to that of the coding of 'midwives'. Whilst I had identified my list of occurrences relating to the NP and capital from a single transcript, for the midwives I created one for the number of occurrences that were mentioned across all the transcripts in the study as a whole. As I identified previously the issue regarding the midwifery service had been identified early on in the study and soon became a noticeable thread throughout, as had the value placed on physical distance. I also noticed a relationship between the two during the early listing that took place and which was also noted in my reflexive diary as the following extract demonstrates:

"There seems to be general tension between the midwives and other professional groups. What I have found in the GP Practices involved in this study is that the midwives work over a large area and aren't actually based at the GP practices: whereas the DNs and HVs are. Maybe it is just physical presence that helps break down the barriers"

(EXTRACT FROM REFLEXIVE DIARY)

When re-reading the texts that related to each of these codes collectively it became evident to me that there was a connection between the two. This came to light through deeper and on-going examination of each of the codes which I then cross-referenced back to the transcripts for verification as to insights drawn. In doing so I concluded that physical distance had been used by participants as a means of obscuring meaning with regards to both their relationship with the midwives and to each other. Therefore, as I identified above, within the theme 'Physical Space and Collaborative Practice', I created a second-level theme called 'Physical Distance'. However from here I then added two additional third-level themes entitled 'Relationships' and 'Midwives'. As I previously stated the same code can be relevant to different threads and therefore appear on more than one occasion and I felt this to be appropriate here. For example in relation to the thread identified above it felt to me as if it was being used to describe how others interacted (or did not interact) with the midwives. However in another thread: 'Social Positions and Collaborative Practice' I identified it as a third-level code under 'Capital' in order to refer to the way in which the midwives interacted (or did not interact) with others. Therefore, whilst the same code was used twice, it was used to reflect different meanings. The thinking behind these themes is discussed in detail in the following chapter.

Whilst I examined some aspects of the transcripts in detail, such as those described above, I analyzed other elements less so. An important part of the analytical process is to identify codes that relate to the central concerns of the study whilst resisting the danger of slipping into undertaking a quasi-quantitative study. This means that areas of particular significance are reviewed in greater depth rather than simply analyzing all the text to the same depth (King, 1998). For this reason some codes that I identified initially were withdrawn once deeper understanding of what was happening took place, whereas others were amalgamated. For example, whilst 'conflict' had originally been identified as a theme within the early templates I created it was the factors that created and prevented conflict that I later felt to hold more meaning and in particular in relation to the overall aims of this study. As such I included it in the final template but as a third level code in relation to the student experience.

Crabtree & Miller (1999) describe the process of interpretation as a 'complex and dynamic craft' (p128) involving many stages and perhaps the hardest stage of all is deciding when the final template has been created (King, 2004). One way to decide this is to ensure that all transcripts have been re-read and the codes scrutinized no less than twice, although commonly this process is undertaken more frequently (King, 1998; 2004). In addition time constraints will play a role in making this decision as all studies will have a need to be completed within a finite period of time (King, 1998). My study was no exception. As the

analytical process is dynamic there is no clear-cut end to the process in the same way as occurs in quantitative studies (Crabtree & Miller, 1999). However it should be clear and comprehensive to the reader (King, 2004). In this study, I read and re-read the transcripts to ensure deep and extensive understanding of what was happening. To this end I felt that the 'final' template I created appropriately reflected the findings of the study at the relevant level. The following two chapters demonstrate what was achieved.

Chapter Four

Findings Part I: Findings relating to Collaborative Practices

Introduction

In this chapter I present the first part of my findings, with the focus on how participants from varying professional backgrounds experience their relationships with others in primary care and the factors which impact on doctors and nurses collaborating. I will focus on the student experience in the following chapter.

The Findings

Alongside the initial thoughts about each of the Practices that I presented in chapter three, I attempt here to present the way in which I made deeper sense of the data. I use Bourdieu's theory of social life and in particular, his theory of physical and social space (Bourdieu, 1979) as a theoretical lens in order to aid this process, in particular the way in which the physical space of the GP Practice was used and how the staff perceived this. Bourdieu (1996) argued that it is important to consider the inter-connection between the physical space (in this case the GP Practice) shared by the different teams and the 'social space' (the characteristics, status and associated power) which separate them. The positioning of teams within a physical space, he argued, will be influenced by the social space between them. Equally, the construction of physical space will reflect the social space of the teams that it is intended to house (Bourdieu, 1996). In this way both will subconsciously influence each other and impact on how teams engage (Bourdieu, 1996). In considering the issue of space I analyzed both my transcripts from the focus groups and the field notes from my observations in order to explore their CPs and those factors I believed impacted on them. In doing so I identified four themes from my final template (identified in Table Six in the methodology chapter) as follows:

- Physical Space and Collaborative Practice
- Making an Effort to Engage
- The Social and Physical Space Relationship
- Social Positions and Collaborative Practice

I use the remaining themes from my final template in order to present my findings in the following chapter (chapter five).

Theme One: Physical Space and Collaborative Practice

A significant theme in the literature in inter-professional collaboration is the significance of co-location and physical proximity. For example, Kilpatrick et al (2011) found that co-location and object-centred team working was an important factor in the development of nurse practitioners as effective boundary spanners in Canada. However, Jesson and Wilson's study of the integration of pharmacists within primary care centres (2003) suggests that proximity did not necessarily solve issues arising from misunderstandings of professional role and identity, and could be seen as compromising professional autonomy for pharmacists. Equally, Gum et al.'s (2012) study of the nursing station found that staff used physical space territorially and in a manner which reflected their own perceived authority over a given location.

In this study, being located within the same physical space did appear to have a significant influence on CP for the teams involved in the study. One example of this was a response I received when asking how well one team worked with other teams in the Practice, which received the following response:

F: "I think we're really quite well integrated here"

ME: "What do you think it is about the Practice then (...)?"

F: "(...) we're based within the Practice"

(PRACTICE TWO DN F)

This response was given despite the Practice being relatively large and staff being located across two separate floors. Teams at Practice Three, despite being larger still, made similar responses and believed that they had regular interactions with other teams because of their physical presence as the following extract shows:

M: "One of the critical things is that the health visitors and district nurses are based in the building"

(PRACTICE THREE GP M)

As with Practice Two some of the community teams at this Practice were located on a different floor to the GPs but none considered this an inhibiting factor to the positive CP they each described. Other teams, however, felt that it was not just the physical presence of the teams but also the physical distance between them that was significant. Staff at Practice One, for example, felt it was the combination of both the physical presence and the close physical proximity of the different teams that was significant to the positive relationships they felt existed at that Practice as the following extract shows:

F: "I think that everybody's in the same building on the same floor (...) but I think that's really important because even when you have two floors and say you know the community staff are upstairs and you're downstairs, I know it's only a flight of stairs but it makes a big difference isn't it to go upstairs and talk to them whereas when you're on the same floor (...) it's no real big effort to pop round into anybody else's room"

(PRACTICE ONE GP F)

In contrast to the other two Practices, Practice One was small and single-storey with all staff located in close proximity to each other and thus for them it appeared to be both physical presence and the actual physical space between the staff that they perceived to be significant. Other teams also described physical proximity as being significant but their idea of the influence of proximity or distance appeared to be applied conditionally. Specifically staff seemed to use it in two ways. Firstly, as highlighted above, it was used to confirm the sustaining of positive CP that was already in place. Conversely, it was used as a means of justifying poorer CP between specific teams as the following extract taken from the focus groups with the GPs in Practice Two shows. Here, as I identified in chapter three, they had highlighted difficulties in relationships between themselves (the GPs) and the midwives and that it was the physical distance that they believed to be a significant, contributory factor to this:

F: "(...) their room's through there so geographically she might come through here just to say 'hello' or they come and go and we'd never know they're here so that makes midwifery a separate, they don't really feel part of the practice (...)"

(PRACTICE TWO GP F)

This however was different from the perception of the DNs at the Practice who believed that the CP between themselves and the GPs was good despite their being based some distance apart, as the following extract shows:

F: "I think we're really quite well integrated here (...) even if we are **shoved up** in the loft somewhere"

(PRACTICE TWO DN F Emphasis Added)

My analysis suggested that the close proximity of two teams did not necessitate positive, interprofessional working relationships; but only that this was perceived to be the case. A further example of this at Practice Two was the location of the HVs relative to the GPs. Unlike the midwives and the DNs, the HVs were located in an office close to the GPs. Despite this, the GPs identified that CP with this team was poor as the following extract shows:

M: "Health Visiting is complicated, a bit of a problem for us actually within the practice in that they're not quite as accessible as our previous team were"

(PRACTICE TWO GP M)

Where teams were located in close proximity and relationships were poor, teams did not consider the physical space between them to be significant. Conversely, where CP was poor and the teams were located at some physical distance from each other, physical distance was perceived to be a contributory factor. As I highlighted previously this was particularly evident regarding relationships with the midwifery services. Indeed whilst not a specific focus for this study, teams across all three Practices reported a generally poor relationship with midwives: the views of which can be summed up by the administrators at one Practice as follows:

F: "(they are a) law completely unto themselves (...). They (the midwives) haven't got the ethos of this Practice but they are attached to this Practice"

(PRACTICE THREE ADMIN F)

Whilst the DNs and HVs had permanent bases at the Practices and saw only patients who were registered there, the midwives did not. They were responsible for women from across a wider geographical area and only attended designated Practices on specific days to undertake clinics and see women attached to that Practice. Despite this difference in working practices, however, it was the physical space between rooms that teams identified as being a significantly influential factor. One example of this was provided by the GPs at Practice Two as follows:

F: "So their rooms through there so geographically she might come through here just to say 'hello' or they come and go and we'd never know they're here so that makes midwifery a separate, they don't really feel part of the practice"

(PRACTICE TWO GP F)

Despite this there appeared to be a positive relationship between the GPs and the DNs at this Practice: notwithstanding their being located some distance from each other and further away than from the HVs. With the HVs proximity was not considered a factor, but instead issues raised by the GPs related to the motivation of that specific team to engage. With the midwives the distance was seen to be problematic as it impacted on the ability of the midwives to make an effort to engage. It appeared likely, therefore, that the physical space between different professional groups did not necessarily contribute to positive CP itself but was used as a means of validating it where it was considered to be present and of justifying its absence where it was not.

Theme Two: Making an Effort to Engage

Whilst additional influences appeared to be at play the teams themselves seemed to be either unaware of, or feel unable to articulate, what these maybe. However, by using Bourdieu's theory as a theoretical lens, it appeared to me that the effort that teams made to sustain positive CP was influential. Bourdieu describes life as a game with interactions affected by a multitude of differing factors with one of these being 'playing the game'. Behaviour will be inextricably linked to future consequences and expected rewards that any behaviour will bring (Jenkins, 1992). Thus if the effort (the movement across physical space) to engage enabled (perceived) positive CP to be sustained, then the future consequence rewarded that effort to be continued. Comments made in the focus groups appeared to validate the relevance of this theory to my findings. The following extract was made by a DN at Practice One. As I had already established above teams at this Practice had confirmed that they felt physical presence and distance to be significant contributory factors to the attainment of positive CP. However from comments made it was also evident that they considered their personal effort to engage as being significant:

F: "You have to be very careful because (GPs) don't have set lunchtimes so you always have to be careful sort of making sure they have got the time to speak to you"

(PRACTICE ONE DN F)

What was apparent was that staff only identified the effort they made to engage when describing CP they considered to already be positive. Thus there was a contrast between validation and justification of the effort made to engage (or not) in CP dependent on whether relationships with others were considered positive or not.

As I already suggested Bourdieu describes life as a 'game' (Jenkins, 1992). The 'rules' of this game, however, are subtle and influenced by a multitude of factors with one key feature being that in 'playing the game'. The behaviours of the players will be inextricably linked to those of the future: based on an expectation of the future rewards that current behaviours will bring (Bourdieu, 1989). Bourdieu describes the level of investment in a field as the 'illusio' (Bourdieu & Wacquant, 1992). A little-discussed, but important aspect of his theory (Colley & Guéry, *in print*), the illusio is inextricably linked to the individual's own habitus and therefore influences the way in which they engage (Bourdieu & Wacquant, 1992). It is only by stepping away from this situation – the 'illusio' – and therefore out of 'the game' that current behaviours will cease (Bourdieu & Wacquant, 1992). Applying this principle to his own study Charlesworth (2000) found that the long-term unemployed in the working class city of Rotherham gave up looking for work because they lost the expectation that the future would bring the employment they desired. In other words, they no longer 'played the game' of searching for work as was expected of them, as they believed this activity would not be rewarded. Similar behaviours seemed also to be at play in this study and the example given below further illustrates this point. Here the quote is made by a GP at Practice Two. Both GPs and DNs had confirmed they believed there to be good CP between the two teams. This was despite the DNs being based some physical distance from the GPs and there clearly being an effort required on behalf of the GPs to sustain that relationship:

M: "I will then go up to the [part of the practice] where we **hide** our community nurses"

(PRACTICE TWO GP M; Emphasis Added)

In this example geographical distance is recognized but not considered an obstacle. Instead it is the effort made to engage that enables positive CP to continue and the effort to engage is justified. Conversely the GPs also identified that there was a physical distance between themselves and the midwives but with this team the relationship is described as poor with physical distance seemingly used to justify why CP was not effective and therefore to provide a rationale for their not making an effort to engage. One GP said:

M: "(...) their work is over in the conservatory so geographically they can come in, do their job and then go out"

(PRACTICE TWO GPi M)

As I highlighted in the previous chapter a further example of this was evident at Practice Three. In this example there appeared to be a sense of despondency as to the

current situation resulting in a feeling that further efforts would be futile. Thus staff had opted out of 'the game' (the *illusio*) as the following illustration shows:

M: "We can't seem to engage the midwives we cannot, for love nor money, we can't get them involved."

(PRACTICE THREE GP M)

What these examples appear to show is that the rationale given regarding the effort made to engage is contradictory depending on whether staff perceived CP to be positive or not. The only exception to this rule was when a previously poor situation altered. As I identified above this lack of effort or opting 'out of the game' was similar to that found by Charlesworth (2000) in his study of the long-term unemployed. In his study he also identified that participants re-engaged with 'the game' when a current situation altered. This was also found to be the case in my study. At Practice One, for example, the HV identified previously poor relationships and a lack of communication with the midwife who was linked to the Practice. This she felt was influenced by the fact that she (the HV) didn't work on the one day that the midwife attended that Practice. However, whilst this logistical factor had not altered, the arrival of a new midwife saw a restored belief in the HVs ability to achieve good CP and thus saw a renewed effort to engage. She said:

F: "The communication between the Health Visitors and the other midwife wasn't very good at all you know they didn't really get much communication; so when this new midwife started I arranged a meeting between her and the Health Visiting team thinking 'oh this is a good opportunity' and err it did work it has worked (...) even though she doesn't work you know the same days as me"

(PRACTICE ONE HV F)

This renewed effort to engage appeared to be initiated by a change to the current situation: the arrival of a new midwife. However, it had not been a requirement of the new arrival but rather was a consequence of it: creating a resorted belief in current behaviours (effort) being able to provide better working relationships than had previously been experienced and overcome any challenges created by distancing which occurred through different (practical) working patterns. I.e.: a renewed belief that current practices would bring future rewards and thus enabled her to return to 'playing the game'.

In the examples provided above the effort to engage in CP was dependent on a number of influences or, as Bourdieu (1989) argues, 'rules' relating to 'playing the game'. These influences were 'physical presence', 'physical distance' and 'effort made to engage'.

Their significance to CP, however, was conditional to the pre-existence or absence of perceived positive CP and where they were absent to influential factors altering, whereby staff members reconnected with the 'game' making an effort to engage even when those factors that had altered were not related to the primary factor that staff believed made engagement difficult.

Theme Three: The Social and Physical Space Relationship

These findings further confirmed that physical presence and proximity of staff did not have primary significance but was significant only in relation to how it was perceived and therefore applied to CP. This was both in terms of how its existence or absence was justified or whether an effort was made in order to (re)establish or sustain it through movement across physical space. However, Bourdieu (1996) argues that the significance of social space is often masked by the visible, tangible, manifestation of physical space. Physical space, he explains, is absolute. It is a clearly observable location. Social space, however, is an "invisible reality" (Bourdieu, 1996; p18) that will have a direct impact on how physical space is viewed, used and distributed by those within it. It appeared that the social space between the different teams was also impacting on CP in this study but that their awareness of this was veiled behind the primary impact they believed physical space to have.

According to Bourdieu (1996) status is reflected in the level of capital held. Those with the greatest amount of capital hold the highest status with capital used to maintain their dominant position whilst others act submissively or subversively in relation to them. Status, he suggests, is associated with 'capital' with those in dominant positions holding the greatest volume. Capital, however can take many forms and can include education, physical possessions and ultimately a set of certain 'tastes' which will then be used to both unite those of a similar status and distinguish themselves from other groups (Bourdieu, 1979). These distinguishing characteristics of any particular group will set them apart from another in a hierarchical way and it is this which Bourdieu (1989) suggests creates the 'social space' between any two groups. The literature on medical hegemony, from Witz (1992), also contains many examples of the way that hierarchical structures can dominate and impair working relationships and is evident in similar studies (for example: Currie & White, 2012; Gum et al., 2012; Jesson & Wilson, 2003): in particular through boundary work used to protect the working practices of those with power (Witz, 1992). In this study I found the high status of the GPs to be reflected in the amount of capital held. A consequence of this was the social space created between themselves and other teams which manifested itself, in one way, by their restricting access to themselves by others. In particular it was the structure of the GP's day which seemed to restrict accessibility as most of their day was constructed without any time being set aside for others to readily access them. However it was the door to the

consulting room which acted as a physically visible barrier and it was this upon which others focused and considered to be the primary barrier. Indeed, as the following extracts show, when asked to describe a normal day the GPs painted a picture of a day spent carrying out one-to-one interactions with patients or in undertaking the additional paperwork associated with this:

Mi: "A normal day for me (involves) getting in to start work at half past eight and doing a full morning's surgery which finishes eventually around 12 o'clock"

(PRACTICE TWO GP M)

Mii: "A normal day for me is get here about 15 minutes before we open the doors at half past eight. Surgery until half past 11 and then visits"

(PRACTICE TWO GP M)

Miii: "Usually manage to get there by 35 minutes past eight; surgery starts at half eight (...) consultation supposed to end by 11:20 but finish by about 12"

(PRACTICE ONE GP M)

In Gum et al.'s (2012) study the focus was on the physical manifestation of the nurses' work station rather than the lack of access to computers due to doctor's (inappropriate) use. In my study staff also appeared to focus on the physical. However, no formal time was built into this busy schedule for others to be able to access GPs if needed for 'ad hoc' meetings. This was despite other teams having highlighted their need to do so. As I identified in chapter three, in order to validate this belief further, I created a series of sociograms following completion of the focus group interviews. In doing so I recorded the interactions between the different professions describing how often and in what way (i.e., face – face, telephone or e-mail), they occurred. I have included a selection of these in figure one in chapter three of this study which illustrate the limited level of interactions undertaken by GPs with other professions and how, when they do occur, that they are generally instigated by themselves. I include, for comparison, an example of an administrator's interactions as well as one from the PN team

One DN team, for example, described the difficulties in reaching the GPs as follows:

F: "(...) by the time we come back and we want to speak to a GP they've gone on their home visits as well, because they've been in surgery all morning (...) but you have to be careful because they don't have set lunchtimes, so you always have to be careful, sort of making sure they have got the time to speak to you (...)"

(PRACTICE ONE, DN F)

These difficulties were reported across each of the different nursing teams and all Practices. In being asked specifically how they did speak with a GP if needed, one PN team responded as follows:

Fi: "We probably have to do more communication by email than face to face than we used to (...)"

(...)

Fii: I can go days without seeing some of the partners"

Fi: you've got to go speak face to face because you never know when you're going to Be getting a reply sometimes"

(PRACTICE ONE PN F x 2)

The structure of the GPs day, therefore, seemed to have the greatest impact on the ability of others to engage with them and required effort being made for them to do so. Whilst it is acknowledged that there has been an increase in the workload of GPs over recent years, the GPs appeared to use this as a further means of creating boundaries and restricting access by others (Charles-Jones et al., 2003; Witz, 1992). Even when attempting to communicate by alternative means, as the PNs report above, they experienced difficulties and access to GPs remained elusive. In comparison other teams were more accessible. HVs, for example, attempted to be available during their lunch hour as the following extract shows:

F: "Most of us will tend to be back in the office around lunch time err just for a quick Lunch-hour again to answer the phones, deal with any calls"

(PRACTICE THREE HV F)

DNs also had set office time built into their day and could be contacted by others at any-time outside of this:

F: "Mobiles: they've all got our numbers"

(PRACTICE THREE DN F)

Whilst other teams were readily reachable, therefore, GPs were not with others trying to catch them as and when they could. On occasions this meant 'hovering' outside their

consulting room door. When face to face contact did occur it was the GPs who initiated it rather than the other way around as the sociograms (in figure one in the previous chapter) showed as well as in the following extracts here:

F: “(They) will come out into reception so I think that’s really good for us because it’s a chance just to (...) get them for something that you might need to pass on”
(PRACTICE TWO ADMIN F)

And:

F: “We tend to work with them a lot really at times, everyday (...) asking them about the results; they ask us to like fax things or chase things up

Me: Okay do you have any sort of formal time (...)?

F: No it’s more like that really isn’t it?”
(PRACTICE ONE ADMIN F + ME)

Where face to face contact did occur it was most frequently between the GPs and the administrators. Despite this it was the GPs who tended to initiate these interactions with the administrators ‘catching’ them as and when they appeared. Despite this greater level of interaction administrators still reported difficulties in accessing the GPs when required. For issues considered more urgent, however, they were unable to wait. Despite this I found that there was a general acceptance of having to do so. For most this was subtle with their expressing a wish not to interrupt the GPs in the middle of surgery. For others, however, it was more explicit and re-enforced by previous encounters with GPs. One administrator, for example, described the negative response she received when interrupting a GP in the middle of surgery. She said:

F: “You can get snapped at if you go into a room, if you continue to go into a room (...) you know you feel like, ‘hmm, I really don’t want to go and knock on his door and bother him again (...)’ you understand it’s the middle of surgery, you don’t want to do it but you can get your head snapped off sometimes”
(PRACTICE THREE ADMIN F)

Thus the power of the GP was influential in others learning the rules of (non) engagement with those holding more power than themselves (Collin et al., 2011). Bourdieu (1996) argued that groups could be characterized by the space they occupied with the level of

accessibility and status also reflected in the physical space each team occupied. The inaccessibility of GPs did appear to be, for example, reinforced by the physical space they occupied and reflect the hierarchical differences in status between themselves and other teams. This was then reinforced by what appeared to be unwritten rules by which each team were expected to engage (or not engage) with them.

These 'unwritten rules' enforced conformity which were regulated not only by those from different professions but also from within individual professions themselves (Bourdieu, 1996). The account of being snapped at, given by the administrator above, for example, acted to reinforce her learnt reluctance to 'interrupt' GPs during surgery (Collin et al., 2011). In addition this rule was further reinforced from within the administrator group themselves. For example, when I attempted to discuss further this negative response it was challenged by other administrators in what appeared to be an attempt to discredit the comments of the first administrator. This resulted in the first administrator attempting to alter the sense of what she had been describing by justifying the behaviour of the GP and thereby reconciling herself with her peers as follows:

F: "I was going to say usually on the whole if they've done that they will come out and pull you to one side, or in front of the other members of staff that they've done it in front of and say, 'I'm so sorry'. You know they're, they're really good at apologizing if they've done it and its being so stressed you know (...) so they are very good at apologizing"

(PRACTICE THREE ADMIN F)

I also found nursing teams had similar difficulties in accessing the GPs. In talking to one DN team, for example, one described 'hovering' outside the GP's door in order to seek a consultation with them. In this example other members of her team also seemed to act to challenge her comments and thus 'regulate' the behaviour of her peer and reinforce the acceptance of their hierarchical relationship (Bourdieu, 1996) as follows:

Fi: "Err usually just hovering outside the door [laughter]

Fii: Well you can plan it round their surgeries"

(PRACTICE TWO DN F x 2)

For both administrators and nurses, therefore, the social position of each is recognized and regulated from within. If someone attempted to criticize a GP, those from within the same profession as the criticizer act to challenge them and ensure their attitudes and behaviours are

altered in order to conform. Bourdieu (1985; 1989) suggested that this is likely to occur in order for agents to be 'conditioned' into reproducing similar practices as their peers and to accept their social position. Applying this theory here it appeared that the elusiveness of the GPs did not have to be solely reinforced by the GPs alone as those for whom it most affected policed their own teams in order to ensure their social positions were maintained. Generally accessibility was restricted by the daily routines in place and reinforced by the physical barriers which conditioned agents into accepting their positions and therefore that of others (Bourdieu 1985; 1989).

Whilst this was evident with the GPs in relation to their own inaccessibility by others, it was also evident in relation to the accessibility of others within the Practice and this too reflected the social position that they held. For example community teams shared a single office space: either as a single team or shared with other community nurses. At Practice One, both DNs and HVs shared an over-cramped room. One DN described this as follows:

F: "There's eight to ten people in this room and they're all women. We're all hormonal (...) it gets quite noisy and quite loud and very warm"

(PRACTICE ONE DN F)

The shared and less spacious physical space seemed to reflect the fact that they held a lower status than that of the GPs. However, although the community staff felt cramped, it was still a contained physical space which was accessed through a door. Conversely administrators were all located together in an open-plan area: an environment which supported their being readily accessible to the GPs and reflected the fact that they held the lowest status within the Practice.

Thus the rules of engagement differed depending on the status of the team: creating an imbalance in their relationships which manifested itself through the level of accessibility to others and self and was reinforced by the physical space each occupied which acted as a form of 'capital'. Bourdieu argues that it is important to consider the physical space (in this case the GP Practice) as being inter-connected with those individuals who are operating within it: the objective-subjective relationship. One cannot exist in its current form without the other (Prior, 2000). Therefore whilst the physical space each team occupied reflected the social position each held within the Practice it also acted as a form of capital which entitled each to that space, based on their social position. Each, therefore, appeared to be inter-related.

Theme Four: Social Positions and Collaborative Practice

It was evident, therefore, that the different teams each considered the physical space to be of primary significance in terms of enhancing CP. However there were clearly other, greater, factors at play that influenced when the different teams engaged and the particular rules of engagement when they did so. In particular: the social space between the different teams and the capital each held, which appeared to reflect their social status within the Practice (Bourdieu, 1989; 1996). I found further influences on CP were also evident in the way in which the different teams communicated with, or talked about, each other: which again also seemed to be reflected in the social position each team held. For example when talking about particular GPs, administrators tended to refer to them by their title as the following extract shows:

Fi: "Dr [name] did it a lot didn't he?"

Fii: Yeah then Dr [name] did it yeah"

(PRACTICE THREE ADMIN F)

GPs however did not reciprocate this and at times described administrators as 'girls' further confirming the inequality in relationships between the two teams, as the following extract shows:

M: "I spend a lot of time with the practice manager and the girls in the office"

(PRACTICE 2GPii M)

Bourdieu (1985) describes the use of titles as 'symbolic capital' (p733): given power by the official and even legal recognition bestowed upon them. In this study the use of the formal title of 'doctor' when talking about doctors seemed to confirm a prestigious position that was recognized by others. However, just as the title of 'doctor' was associated with a position of power, the title of 'girl' appeared to symbolize a position of being power-'less': thus each title reflected the position of the other which was reinforced by its usage.

Bourdieu (1985) also argued that language can be used to identify the social order between different groups and the ways in which each team talked about each other in this study seemed also to confirm that relationships were hierarchical. Although the difference in language between GPs and administrators was particularly evident, there were also hierarchical differences between the GPs and the nursing teams although these were subtler in

nature. In the following quote, for example, a DN is complaining that the GPs do not work in the way their team would like them to work:

F: "I find that the doctors here are reluctant to visit and that they won't visit unless they absolutely really need to do so. If we were to come back from a visit and say 'well they need to be visited' yes they will do that but whereas in other Practices where I have worked doctors have set up a schedule of visits when somebody is terminally ill and increased that as the person comes towards the end of their life that's not something they've taken on board"

(PRACTICE TWO DN F)

In this example, whilst critical of the working practices of the GPs in relation to how they worked with themselves, the way in which the DNs described these working practices seemed to reflect an acceptance that the final decision-making powers rested with the GPs. As such the DNs appeared to recognize the difference in status between themselves and the GPs. In other examples, however, there seemed to be more resistance to this status differential. This appeared to be particularly true if the nurses held autonomy over their own working practices and were not reliant on the GPs as in the example above. For example, prior to sitting in on a meeting at Practice One, I identified a number of questions in my reflexive diary that reflected the aims of my study and which I believed would help me to understand what was happening during the meeting. One question was: 'Does any single profession dominate the meeting?'. In attending the meeting I made a number of field notes which I then added to shortly afterwards. In reading these back it appeared that the GPs had dominated the meeting by asking authoritative-type questions and giving instructions. Conversely the nurses had provided information and received instructions as the following extracts show:

"The focus of the 'session' was on current patients. The first (patient) was presented by a DN and next by the MacMillan Nurse with advice given in response by one of the GPs re medication"

(EXTRACT FROM FIELD NOTES FROM OBSERVATION UNDERTAKEN AT PRACTICE ONE)

And:

"The next patient is presented by the Macmillan Nurse. This is an elderly woman who has problems eating. Advice is given by the first South Asian, male, GP but this advice is clearly not accepted by the DN who doesn't acknowledge this and quickly moves on to presenting the next patient"

(EXTRACT FROM FIELD NOTES TAKEN FROM OBSERVATION AT PRACTICE ONE)

In this second example the nurse appears unappreciative of having received instructions from the GP and although does not challenge him openly, he appears to do so subversively by ignoring his directive and moving on to discuss the next patient. I also recognized this on other occasions as the following extract from my Field Notes shows:

"The next comment came from a male GP who asked: "so the hip pain is worse now?". And on receiving a response from the DN asked: "has he been x-rayed?" After this response was received the GP made a proposal as to what care should be given which the DN appeared reluctant to accept"

(EXTRACT FROM FIELD NOTES TAKEN FROM OBSERVATION AT PRACTICE ONE)

In both these examples the GPs seemed to maintain a position of authority by the way in which they gave directive instructions to the nurses that were present: despite it not being requested. Conversely the nurses appeared to ignore them, subversively, by their lack of acknowledgement of the instructions given. On another occasion, however, the DN attempts to mirror the authoritative-directive style of communication but fails to achieve it as the following extract shows:

"The Macmillan Nurse responds to the GP's question re medication and the new GP, who is holding a set of notes responds, rhetorically, with a question regarding the medication saying: "so that could go up, could it not?" A discussion regarding the medication then takes place. The same GP adds: "yes it could go up by 50?" The Macmillan Nurse also joins in the discussion and directs a question to the DN asking: "so that needs altering then?" The DN attempts to respond with a rhetorical question regarding the need to increase the PRN medication in the same way as the GP but then loses confidence at the end adding: "Yer?.. No?"

(EXTRACT FROM FIELD NOTES TAKEN FROM OBSERVATION AT PRACTICE ONE)

Thus this further confirmed to me that the GPs held the dominant position within the meeting in comparison to the nurses. In noticing the authoritative-directive communication methods of the GPs I also noted how the nursing staff seemed to try to avoid being passive recipients of this. However, their manner also seemed to suggest a reluctance to be confrontational. Therefore by simply ignoring the directives of the GPs I concluded that they were working in parallel to them as the following extract from my reflexive diary shows:

"Staff seemed to be working in parallel at times rather than together. I had noticed whilst observing the meeting how little notice the DNs/MacMillan nurse took of the advice given by

the GPs. The main form of communication used by the GPs was advice giving but advice taking was not the main form of communication used by the DNs and MacMillan nurse (...). The GPs mostly placed themselves in the role of 'advice giver' whereas the DNs appeared to want clarification regarding issues to enable them to make independent decisions. When advice was given that the nurses didn't want, they didn't comment but just moved onto the next patient"

(EXTRACT FROM REFLEXIVE DIARY)

I will provide further evidence of parallel working in relation to the students' experience in the following chapter.

As I identified earlier the language that a person or group of people use can be a means of establishing their social position (Bourdieu, 1985) with those of a lower social position acting subversively or submissively in relation to those of a higher status (Bourdieu, 1986). Thylefors (2011) suggested that doctors had a tendency towards using authoritative language in comparison to nurses and I also found that to be the case here. In the earlier example I gave, for example, it appeared evident that the DNs were acting submissively to the dominant position of the GP by the way in which they fatalistically accepted that the doctors at that Practice would not carry-out joint visits with them. In these later examples, however, the nurses appeared to be acting subversively. Whilst not explicitly challenging the GPs in their position as 'advice givers' the nurses appeared to have adopted an implicit means of communicating that enabled them to ignore the direct advice given by the GPs without directly challenging them. By doing so the higher status of the GPs continued to be recognized by the nurses but they had found a communication mechanism which enabled them to work autonomously, whilst avoiding direct conflict or challenging the established, higher social position of the GP.

It is also worth noting at this point the similarities between the subversive 'side-stepping' of authority in the nurses' behaviour that I identified above and that which appeared to be taking place with the Practice staff and the midwives. As I described in chapter three the midwives were not located full time at any of the GP Practices and were therefore not included in my original study proposal. Nor did I include them in any of my focus group interviews or non-participatory observations. However, GPs, nurses and administrators all commented on the poor CP they experienced between themselves and the midwives and as such I believed it relevant to my study to consider the possible reasons for this. As I previously stated the GPs at Practice Three had been reluctant to discuss what they described as the 'political' issues underlying the problems between themselves and the midwives. The GPs at Practice Two, however, freely discussed what they believed to be the macro-level cause of the problems they

now faced between themselves and the midwifery service as a whole. As the first example illustrates below, this was concealed by the greater emphasis placed on the difficulties of engagement considered to be related to physical space and distance that was commonly used as a 'raison d'être' for poor CP across all professions and consequently, justifying the lack of effort they made to engage. The points I considered to be most noteworthy have been highlighted as follows:

F: "It's been difficult because the midwives have been very separate from a separate place and **we haven't had a choice of who we've had** (...) they only come in one or two days and **I don't think she's in when I work so I don't see her** (...) it's quite hard to get a relationship with somebody, with someone like that and also (...) **their room's through there so geographically she might come through here just to say 'hello' or they come and go and we'd never know they're here** so that makes midwifery a separate, they don't really feel part of the Practice"

(PRACTICE TWO GP F Emphasis Added)

As I stated earlier Bourdieu describes life as a 'game' with expectations based on future rewards. If those expectations are not met then it is likely that those involved will opt out of the game (Bourdieu, 1990; Jenkins, 1992). In the example provided above there appears to be a lack of CP between the GPs and the midwives with physical space blamed for this. What also appears to be evident, however, is that both GPs and midwives have opted out of 'playing the game'. Whilst previous examples of this provided above described individual examples, what appears to be illustrated in this example is that the midwifery service as a whole seems to have opted out of the game. This appears to be linked to power relationships. Indeed, the same GP as in the example above went on to describe the power struggle by the midwives which they (the midwives) appear to have been successful in winning. As before, I have highlighted what I considered to be noteworthy points:

M: "I think midwifery is just so dislocated, I'll go back 30 years or 20 years we had a fantastic relationship with midwives, and **we had really good control of our pregnant patients** and a good service and we had the Cumberland Report and it destroyed everything. So going back, I think it did. I mean **there was this huge power-based fight about midwifery taking over the whole world (...) a lot of good, established, practice was sacrificed because of what happened with the development in midwifery**"

F: "**We've become de-skilled** because I hardly ever do anti-natal practice now"

M: "It was very, very sad. You know we had a couple of hundred confinements a year at one stage and **you would know everything** that was going on with it. Now, I've no idea"

(PRACTICE TWO GPs M & F Emphasis Added)

What these highlighted elements of the text appear to show are that the GPs identified both a loss of power and control over their patients and also over the midwifery service: who they appear to blame for taking this from them. It is this, however, which seemed to be manifesting itself into the conflict identified as an issue with physical presence and space, rather than the underlying issue of power and control, that were being described in the extract above. As I gave this issue further thought I discussed it with a midwifery colleague and recorded it in my reflexive diary as follows:

"In reading through the literature however, it occurred to me that the midwives may have traded-off involvement in the MDT (multi-disciplinary team) for power and status. Working at a distance from the GPs perhaps means that they are able to work more autonomously and hold a higher status than if they were based at the GP practice. As with nursing, the model within which midwives work is arguably incongruent to that utilized by medicine. In midwifery however the desire to ensure a person-centred, arguably feminine, approach to care appears to be further re-enforced by the female client group that have equally come to reject the medical and arguably patriarchal model of care (Murray Davis, 2008). I tested this theory out on a colleague at work who is a midwifery lecturer. She felt very strongly that GPs wanted to 'medicalise' pregnancy and continue to see pregnant women as they would get money for doing so. However, she felt that they should only get involved if there are complications. Pregnant women, she argued, are healthy and want to be treated as healthy women. Perhaps being based outside the GP practice enables midwives to provide this".

(EXTRACT FROM REFLEXIVE DIARY)

Bourdieu (1979) has argued that social space is an invisible set of relationships which translates into a set of distributional relationships in terms of the physical position a person or group will hold within a given space. This physical space, Bourdieu continues, is directly related to the amount of capital that is held. Thus: the social positions of those within a physical space manifest themselves into the positions each takes within that space. By disassociating themselves with this power-'ful' control the GPs had over the physical space within the GP Practice the midwifery service seemed in effect to have succeeded in side-stepping the GPs authority and provide the autonomous service for women during pregnancy that they believed was right. Conversely the GPs, as highlighted in the examples provided above, appeared to recognize their loss of power and control over the midwifery service.

However, whilst this is acknowledged in the example provided above, the additional comments made both here and in those examples provided earlier in this chapter suggest that the loss of control over the midwives (and consequently pregnant women) manifest themselves into a primary focus upon the impact of physical presence and physical space.

Just as the midwives had increased their power and status by physically distancing themselves from the GPs and side-stepping their authority, it appeared to me that the nurse practitioners (NPs) had increased their power and status by physically distancing themselves from their fellow nurses and associating themselves more closely with the GPs. As I explained in chapter three for the purposes of this study the nursing teams had been sub-divided by roles being categorized as: district nurses (DNs), health visitors (HVs) and, practice nurses (PNs). By error I had omitted to include the NPs when organizing my focus groups. This only became evident when carrying-out the focus group interview with the GPs at Practice One when one of those present introduced herself as an NP. This again occurred when interviewing the GPs in Practice Two. It was unclear whether there was a NP at Practice Three but none were introduced, nor mentioned by others, at any time during the study. Unlike the others involved in the study, therefore, the NPs self-selected which focus group they would join and in doing so opted to join the GP focus group rather than any which included their fellow nurses. As I discussed in chapter one, Witz (1992) used the term 'boundaries' to describe the strategies used by professions (and medicine in particular) in order to sustain positions of power by monopolizing areas of work and preventing opportunities from others (beneath them) to access it. Building on this theory Witz (1992) further describes different closure strategies used in order to achieve this. One such strategy is named 'demarcationary' and is described as a means by which certain groups encircle themselves within specific spheres of competence in order to protect their work and place them at a higher hierarchical position than others considered to be of a similar status. By aligning themselves alongside the GPs in this study the NPs appeared to be attempting to encircle themselves in a position hierarchically above their nursing peers and thus protect and increase their own professional position. In considering this I then returned to my transcripts to test this hypothesis.

Bourdieu has argued that social 'classes' can be categorized by those who share a similar set of 'lifestyles' and that the grouping of individuals as a social 'class' results in a 'symbolic space' being created between themselves and others through the physical differences (such as a particular way of speaking) that is subsequently created. This distinction not only enables those within the same social class to identify with each other, but also serves to distinguish themselves from others (Bourdieu, 1996). Bourdieu (1996) also goes on to argue that the physical manifestations of a 'class' of people, such as the ethnicity (or in the case of this study, professional identity), of those within the identified group often

serve to mask the 'symbolic space' created by the lifestyles that are the primary reason for people coming together to form a social unit or a 'class'. Within this study 'natural groups' appeared to have been formulated by both profession and roles as identified above. In having omitted NPs from this grouping, however, they were left to associate themselves with the 'group' of their choice and in doing so both those involved in this study chose to associate themselves with the GPs, rather than with those from their own profession.

Because I had used audio, rather than video, recording of the focus group interviews it was not possible for me to identify clearly when the NP had been speaking during the focus group interview at Practice One as there was more than one person of the same gender as the NP that was present. However the focus group interview with the 'GPs' at Practice Two had been organized by the Practice Manager who had arranged for me to carry them out in two smaller groups based on their availability. This resulted in one of the interviews taking place with one (male) GP and one (female) NP: thus enabling me to be able to distinguish clearly between the two. This meant that I was able to read the transcripts closely in order to examine the interactions between the two participants. I provided extracts from the transcripts in chapter three, demonstrating how this analysis took place.

Having associated themselves with the GPs, the NPs seemed to recognize that this group (or 'class'), held a higher social status than their own nursing profession and as such chose to emulate themselves with them rather than their own peers. As previously argued, Bourdieu (1996) stated that the capital held by any given individual or group will be directly related to their level of power. Most often this capital will be symbolic and can differ in different environments, dependent on that which is considered of greatest value. In considering this in relation to the GPs, factors such as physical space, elusiveness, communication methods and titles used were all identified as forms of 'symbolic capital'. In chapter five, a number of additional examples of symbolic capital that directly related to the student experience will also be described. In relation to the association of the NP with GPs, however, it was evident that the NPs attempted to acquire equal social standing with the GPs by showing that they too held the same level of social capital, through aligning their role closely to that of the GP. For example, as previously identified, one of the first questions asked of staff was to describe their everyday role. In doing so the GPs were specific in terms of what they did. The NP, however, used this opportunity to associate her role, again, with that of the GP. She said:

F: "I don't do home visits, which is the main difference between me and the GPs here ..."

(PRACTICE TWO NP F)

Symbolic capital, as was argued above, will reflect the status and power of the group or individuals who will make sense of it and give it value (Bourdieu 1996). By associating her own role closely to that of the GPs the NP both: recognized the higher status of the GP and; attempted to inflate her own status by assimilating her own roles with those of the GPs. A further example of this is evident in the following extract:

F: "It feels like that sometimes, where we're in **our** little rabbit hutches seeing one patient after another"

(PRACTICE TWO NP F; Emphasis Added)

From the initial examination of the transcript of this focus group interview, it did appear that there were some similarities in the roles and positions of the GP and the NP, which could reflect a similarity in hierarchy and status. Through further consideration of what was happening however it became evident that there remained an imbalance of relationships between the GP and the NP. Whilst the NP held some capital beyond that of her nursing peers, it was not sufficient to give her equal standing with that of the GP. Bourdieu (1979) suggests that the weight and quality of capital will impact on the social position that is held. Whilst the NP was keen to identify similarities between her role and that of the GP, by simply stating these differences acted to stand her apart and below the social position of the GP. In relation to the introduction of NPs and the redistribution of work, Charles-Jones (2003) suggests that the original 'domain' of the GP hasn't altered. Instead, patients are categorized in terms of the severity or level of interestingness of their condition with those considered less complex or interesting being redistributed. Equally when considering the concept of boundary work and the role of the NP Kilpatrick et al. (2011) also argues that the peripheral areas of the boundaries are fluid, enabling over-lap of work to occur. This allows some elements of work to be shared without challenging what is considered to be the 'core' aspects of medical work. Thus: whilst the NP seemed to consider herself to be doing the same work as the doctor and therefore of similar status; the doctor did not.

As previously stated, Bourdieu (1985) also considers language to be a form of capital. Throughout the interview, the NP looked for opportunities to associate herself, through the language that she used, with the GP present and with GPs as a whole. This was not, however, reciprocated by the GP. In the following extract, for example, the NP attempts to describe herself as part of the GP team. As previously, what is considered to be the relevant point has been highlighted:

F: "Reading through I think that's true. I mean [name of GP] probably does it

more than **any of us** really”

(PRACTICE TWO NP F; Emphasis Added)

In addition to associating herself with the GPs, she also attempted to seek agreement with her views from the GP present, further confirming the difference in status between the two. This is highlighted in the following extract with the key elements highlighted:

F: “And it’s not just for information like, **like [name of GP] is saying**, it’s actually really supportive cause **like [name of GP] says** exactly”

(PRACTICE TWO NP F; Emphasis Added)

Again, this behaviour was not reciprocated by the GP. As identified previously, the way in which the different teams communicated with the GPs reflected the difference in status between them. The nursing teams, for example, used either submissive or subversive methods of communication. Whilst the NPs identified possession of additional symbolic capital above and beyond that of their other nursing counterparts, the use of what appeared to be submissive types of communication, demonstrated that there continued to be a difference in status between themselves and the GPs, despite their attempt to increase their social status by assimilating their roles with them (the GPs).

In returning to the social position of the different teams generally, the final factor that I found to differentiate the status of the different teams was the tasks that each performed. The tasks that the administrators carried out, for example, were widely diverse but aimed at meeting the GPs’ needs. This encapsulated anything from making cups of tea for the GPs, to inputting data. In fact, there appeared to be a sense of duality to their roles. On the one hand they were expected to work autonomously and ensure the Practice functioned efficiently and effectively by ensuring information flowed in and out as required. On the other, there remained a more traditional feel to their role; being more of a ‘handmaiden’ to the GPs with an expectation that they would be available to respond to the requests of the GPs as and when they were made. When asking one team if they saw themselves as empowered or handmaidens one administrator responded as follows:

F: “I think it’s a bit of both really isn’t it (...) anything the doctor wants we’ll do”

(PRACTICE THREE ADMIN F)

And another:

F: "Basically we put everything on a plate (for the GPs)"
(PRACTICE THREE ADMIN F)

The administrators also provided specific examples of tasks that they undertook which further confirmed the handmaiden role they carried out as the following extract shows:

F: "Say about quarter to eight I err open all doctors' rooms and put, you know, who's in what room and put the phones on"
(PRACTICE ONE ADMIN F)

It was apparent, therefore, that there was a clear imbalance in relationships between the teams based within the physical space of the GP Practice. GPs, being of highest status, were the least accessible; had administrators readily available to them at the times they required and; had mundane tasks carried out for them. Administrators, conversely, being of the lowest status, were the most accessible; were readily available to meet the needs of the GPs at a time they (the GPs) required and; carried out mundane tasks for the GPs. The nursing teams, however, held a status between that of the GPs and the administrators. Whilst not required to carry out mundane tasks for the GPs as the administrators did, they did have to carry out mundane tasks for themselves in a way that GPs did not. Whilst administrators turned the telephones on for the GPs for example, nursing teams were responsible for their own telephones. One team, for example, explained how their first job of the day was to check the telephones for any referral messages left on the answer phone overnight. Others also described mundane tasks they completed. At one Practice, for example, the practice nurses described one of the first tasks of their normal day as follows:

F: "There's always sort of preliminary things as well to be checking (...) you know, emptying bins and all those sort of clinical type of housekeeping type of things"
(PRACTICE ONE PN F)

Examples from other nursing teams also reflected this hierarchical status of being 'in-between' the GPs and the administrators. When describing the start of their day, for example, the DN team at one Practice described the completion of tasks that administrators completed for the GPs as the following extract shows:

F: "We get patients who ring up and might need a visit who've got a blocked catheter or we get the residential homes will ring up and say somebody's had a bad fall or they've got a skin tear err

ME: So who do they ring?

F: Here they ring our, our office

ME: Right so they don't go through the GP practice at all so although you're based here the referral systems sit here?

F: They do for fax referrals that we get for planned visits from the hospital they come through the GP's fax machine but it's only because the fax machine's downstairs"

(PRACTICE THREE DN F)

Equally, HVs described a similar start to their day:

F: "We would always take the messages off the phone first wouldn't we because if anybody had left any messages after we'd finished five o'clock-ish the previous evening they can be picked up in the morning"

(PRACTICE TWO HV F)

Therefore, the tasks and communications between the teams reflected the difference in status and social space between them.

Discussion

As was identified in chapters one and two, the coming together of different professions under the one roof of the GP Practice was considered an important way of enhancing CP (DH, 2005; Hudson, 2007). This was one initiative of many aimed at enhancing CP and followed numerous Government Inquiries identifying poor CP which resulted in harm and the deaths of a number of individuals and children (for example: Kennedy 2001; Laming 2003; Radford 2010; Smith 2005). Those interviewed in this study believed that being physically located within the same geographical, physical, space, had been a successful way of enhancing CP for them, in all of the three GP Practices. A key finding of this study, however, was that the influences on CP were complex and that rather than physical space enhancing it, the interplay of social and physical space played a significant role in creating and sustaining the hierarchical relationships that were found to be in place between the different teams. Those involved in the study however, appeared not to be aware of this: using physical distance as an excuse when CP was poor and physical proximity as confirmation of their beliefs when it was considered good.

As discussed in chapters two and three Bourdieu describes specific areas of society as 'fields' with those who are a part of that field conforming to the implicit rules that are understood and practiced by those who form part of that field (Bourdieu, 1989; 1992). Whilst not specifically identified as such by Bourdieu himself, I found the GP Practice and those who practiced within it to meet Bourdieu's criteria of a 'field' with implicit 'rules' laid down in order for those within the field to conform to the rules of this field or 'game'.

I also found evidence to suggest that the social space between the teams reflected the power and position between them and was inter-connected with how the physical space was used: both restricting access for those who held the highest status (i.e. the GPs) and facilitating access for the remainder. As previously stated, Bourdieu (1996) suggests that the distribution of physical space will be influenced by the social position each team holds. This was indeed reflected within this study. What was also evident, however, was that rites of access into different teams' physical space, and therefore to the teams themselves, was also influenced by the social position of each team and reflected the boundaries placed around them (Witz, 1992). However, whilst teams appeared unaware of the influence of the social-physical space relationship at a conscious level, the taken-for-granted practices in place continued to affect how they viewed physical space and interacted within it. The nursing teams, for example, seemed to recognize their (lower) status in relation to the GPs, and as such appeared to accept having to manage their time in such a way as to enable them to 'catch' GPs between surgery and home visits as well as by 'hovering' outside the GP's door. Regulation of this practice was managed both from the responses received from GPs and from within their own team, confirming what appeared to be a taken-for-granted appreciation of the social position that each held. Conversely whilst there was an acceptance of the restricted access to doctors; both nursing and administrative teams were keen to emphasize their own accessibility to others. Thus the rites of entry into the GP consulting room by others reflected the (higher) hierarchical position the GPs held. Conversely, the desire to be readily accessible by the remaining teams seemingly reflected the lower hierarchical position that they held in comparison. This further confirmed a taken-for-granted appreciation of the different teams' social position within the Practice.

There also appeared to be a taken-for-granted appreciation of the social status associated with a private consulting room. This was most evident in the NPs who seemed to recognize the capital that was associated with physical space and used it as a means to affiliate themselves with the GPs and, usurp themselves from (and above) their peers (Bourdieu, 1996; Witz, 1992). Despite this I found their hierarchical position remained lower than that of the GPs. One reason for this appeared to be that they failed to hold the same level of additional capital as the GP (Bourdieu, 1996). In particular the NPs' means of

communication set them apart (and below) that of the GPs as they frequently sought to affiliate themselves with the GPs in a way which was not reciprocated.

In chapter one I identified a number of different influences on what was described as the 'doctor–nurse game' (Stein, 1967; Stein et al., 1990). One such influence related to means of communication. Doctors, for example, seemed to use communication in order to support their position as leaders of the interprofessional team by using language which reflected their decision-making powers (Thylefors, 2011) and by nurses seeking guidance from them (Farrell, 2001). Bourdieu (1992) describes the power of communication as a 'linguistic market' (p78) whereby the social position of the individual speaking will provide greater credence to that which is being said. In this study it was found that the specific way in which the GPs communicated was both authoritative and directing. As such, what was being said, and the way it was being relayed appeared to confirm their authoritative position. Conversely, the way in which the NPs communicated in this study seemed to confirm their continuing to adopt a 'guidance-seeking' role (Farrell, 2001) as they sought reassurances from the GPs in their attempt to demonstrate equal status with them. Despite their attempts at usurpation (Witz, 1992) this very act appeared to reflect an appreciation that GPs held a dominant position above themselves (Bourdieu & Wacquant, 1992). The power of language, Bourdieu & Wacquant, (1992) argue, comes from outside. It is not simply the authority of the words that are spoken that demonstrates authority, but the recognition of that authority by others. The linguistic characteristics of the dominant are an outward expression of their position of authority. The consequence of this was to set the NPs apart from the GPs, rather than affiliate themselves with them, as they desired

In chapter two I also argued that students were socialized into a professional way of 'being' (Chambers & Narayanasamy, 2007; D'all Alba, 2009; Owens & Dearnley, 2011) which generally occurred through pre-reflexive, taken-for-granted, practice (Goldie, 2012). The inability of the NPs to cast-off their previously learnt means of communicating suggested an indoctrination into this way of 'being' that they were unable to shed despite their perceived elevated status. Indeed, as Bourdieu (1979) suggests, class can be described as a set of 'tastes' which unites individuals together as a group, or class, and distinguishes them from others. As such, the learnt tastes of nursing suggested that the NPs continued to be set apart from the GPs due to the language that they used (Thylefors, 2011). Therefore, despite the NPs' desire to associate themselves with the GPs, there seemed to be inert differences between them that would eternally set them apart. Bourdieu (1979) also argued that there are certain elements of life that are 'binary', meaning that something has to be one thing or another: a female cannot also be a male and in the same way, a nurse cannot also be a doctor. From the interactions that occurred, it appeared that the NP was attempting to usurp

her status by suggesting that she undertook the same role as a doctor and as such became the same as a doctor, rather than considering the uniqueness of her role as holding greater capital in its own right.

As I previously stated Bourdieu (1985; 1989) argues that the acquisition of capital should not be considered alone. Capital which can be associated solely with those who are considered to hold a high hierarchical position can quickly change and become popular amongst those considered to hold a low(er) hierarchical position. As such it is important to consider a number of further factors including what Bourdieu (1985) describes as the 'habitus' (the disposition) of the individual. The habitus, he suggests makes up the inherent element of who a person is and also therefore: what they think, how they dress, how they behave and how they speak. With regards to the NPs this certainly appeared to be the case. Whilst the NPs held one form of capital in terms of having their own private physical space, the language used suggested a difference between them which formed part of who they were – or indeed who they had become (i.e. a nurse, as opposed to a doctor). I found it possible, for example, to align them with their nursing peers, who held similar 'tastes' in the form of communication used (Bourdieu, 1979). As previously stated, students are immersed into a professional culture which influences not just what they learn but how they learn it (Nairn et al., 2012) and ultimately shapes their professional identity (Holyoake, 2012). This then molds individuals who are defined through their habitus, therefore, as primarily a doctor or a nurse (Bourdieu, 1985). The way in which the NPs communicated in this study, in seeking reassurance, was one example of their habitus which had shaped their identity and as such inextricably bound them to their nursing peers through a learnt set of tastes (Bourdieu, 1979). Therefore, due to the differences between what Bourdieu (1985) describes as the 'habitus' of the NP and her 'being' a nurse, I believed that this desire to also 'be' a doctor could never be fulfilled. Equally, therefore, the attempt to use this affiliation to achieve equal status, failed.

As I also identified in chapter one, Stein (1967) and Stein et al. (1990) had identified a 'doctor-nurse game' whereby hierarchical demarcations could be identified from the ways in which doctors and nurses communicated. Whilst Stein et al. (1990) considered these to have been greatly reduced in his later study the evidence from the study described here suggested that these games remained in play but that they were subtle in nature. It has been argued that behaviours in the workplace are learnt through conflict and power relations (Laver & Wenger, 1991). This appeared to be the case in this study whereby hierarchical positions appeared to lead nurses to continue to learn the implicit 'rules' by which they could work with the GPs (Collin et al., 2011). What appeared to have altered, however, was the way in which the nurses used subversive language in order to maintain their autonomous position that was not in place at the time of Stein's first study (1967). In their examination of work-

related power relations Collin et al. (2011) found that pre-existing rules regarding power relationships were also crossed at times in order to contest implicit boundaries of control. In a similar way the nurses in this study appeared also to do the same. Whilst I found there generally to be a culturally, collective, understanding of how interactions 'should' occur which respected pre-existing power relationships (Collin et al., 2011), I also found the nurses to have learnt subtle ways of avoiding conflict whilst simultaneously both maintaining their own position and seemingly maintain pre-determined rules of engagement (Laver & Wenger, 1991).

As suggested in chapters one and two, the move of nursing education into higher education establishments (Jones, 2004a; Jones 2004b) and the introduction of the extended role (DH, 2000) were introduced as a means to increase nurses' status and is suggested by some to have achieved this (for example: Snelgrove & Huges 2000; Harmer 2010). Certainly, nurses' roles have become more autonomous in nature with their now being expected to work as analytical problem-solvers and decision-makers (NMC, 2010). What was apparent in this study, however, was that their social position in relation to the doctors remained unaltered with their implicitly learnt means of communicating with the GPs reflecting this (Collin et al., 2011). Bourdieu (1992) suggests that tastes are continually changing, which influences the value of the capital associated with it. In particular, as something gains in popularity or accessibility, the level of value it holds will decrease. Therefore, simply making higher educational attainment more accessible will not, I would argue, enable the dominated to gain equal standing with the dominant. As such, the attempt to use this form of capital in order for nurses to achieve equal status with doctors, has also failed.

Doctors have been found to hold decision-making powers beyond that of nurses (for example: Adamson et al., 1995; Farrell, 2001; Quinlan & Robertson, 2010; Vogwill & Reeves, 2008) and in this study this was reflected in the ways in which they communicated which I found to be instructive in nature. Despite their evolutionary change into autonomous practitioners nurses continued to engage with the GPs in both subversive and submissive ways. This suggested that nurses had learnt a way of working with doctors which enabled them to work autonomously, without challenging the authoritative boundary of the GPs' position (Witz, 1992). In considering the way in which the NP communicated with the GP for example, I found it to suggest an inert submissiveness by the way in which she continually looked for recognition and affiliation. This was equally true for the DNs who appeared to accept that the GPs had the final say with regards to joint-working practices. For others, however, subversive means of communication were used in order to facilitate their autonomous working practices. Whilst the level of the nurse's autonomy has increased greatly since Stein's (1967) early work, it has been suggested that doctors continue to influence the day to day work of the nurse (for example: Collin et al., 2011; Fagin & Gaerlick, 2004). The

directive nature of the GPs' communications in this study suggested that they were still attempting to do so. The side-stepping of the questioning by the nursing staff, however, suggested that they had found subtle ways of avoiding this (Collin et al., 2011). In Stein's (1967) earlier study, nurses had found ways of communicating with doctors subversively in order to advise and guide doctors without their realizing this and therefore avoiding conflict. In this study the nurses appeared to be continuing to communicate subversively with the GPs but that now this was to enable them to work autonomously without causing conflict.

It appeared therefore that nurses had learnt unwritten rules of CP that was an inherent part of their habitus (Collin et al, 2011). For the NPs this appeared to symbolically separate them out from the very group they sought to identify themselves with. For others, it enabled them to undertake their role without challenging the social space between themselves and the doctors. This seemed to be in direct contrast to the midwifery service that appeared to have emancipated themselves from the direct authority of the doctors and take control of their own professional lives (Kincheloe & McLaren, 2005). Stein (1967) had suggested that 'good' nurses learnt how to undertake their roles whilst maintaining their hierarchical position and thus avoid conflict. Where this didn't occur, however, difficulties ensued resulting in individual nurses being considered unpopular and failing to progress in their career or leaving it altogether. Similarities were seen between what Stein (1967) described and the findings of this study. As described above, for example, 'good' nurses had learnt to do what Bourdieu described as 'playing the game' (Jenkins 1992) and avoid conflict. When this didn't occur, however, individuals or teams were considered 'unpopular' and each 'side' withdrew from the game. This principle was magnified with the midwifery profession as a whole. Whilst nurses appeared to 'play the game' and 'enjoy' a certain level of autonomy by subversively side-stepping the directives of the GPs, the midwives appeared not to 'play the game' but rather to have opted out of it. Whilst this appeared to have enabled them to enjoy a level of autonomy, it also seemed that they were challenging their social position and the result of this was that they had become unpopular with those who were still involved in 'the game'.

Whilst those factors that had a hierarchical influence on CP between the GPs and the nurses were subtle, it was highly evident between the GPs and the administrators. As previously discussed, Bourdieu (1989) argued that teams tend to be physically segregated in ways which reflect their position with the physical space they occupy reflecting the amount of capital they hold. Equally, however, he argued that the physical space of each team reflected a distinction in their lifestyles (Bourdieu 1995), reflecting the differences in their daily lifestyles (Bourdieu 1989). The role of the administrator, as described by themselves, was to serve the GPs and the physical space they occupied reflected this: assuring that they were readily accessible to the GPs when required. In addition, by the administrators carrying out the

menial tasks it meant that the GPs were relieved of doing so and could continue to undertake roles that held greater capital. As such, not only did the undertaking of menial tasks reflect the lower social position of the administrators but the role of the administrators itself, served to sustain the senior position of the GPs (Davis, 1992).

Conclusions

In conclusion therefore, the social-physical space relationship of the GP Practice served not only to reflect the hierarchical differences between those that it housed, but also to sustain them. Lifestyles and learnt, indoctrinated ways of being further reinforced this, producing a complex interplay of engagement and use of space that went far beyond that appreciated by those based within the GP Practice. The belief, therefore, that housing different professions within one physical space would enhance CPs appeared over-simplified and simply acted to enable the hierarchical relationships to continue.

Chapter Five

The Student Experience

Introduction

In this chapter I build on the findings presented in the previous chapter whereby I found that the social space between the teams influenced the distribution and use of physical space within the Practice in a way which went unrecognized by those involved. In this chapter I am now concerned with the factors that impact on non-formal interprofessional education with medical and nursing students. Of particular concern is the extent to which hierarchical cultures, and the way they are inscribed in social space, affect the capacity for medical and nursing students to engage in genuine inter-professional practice and learning.

The Findings

An important key issue in the CP and IPE literature is the emphasis placed on clinical practice as a place of learning (GMC, 2009; NMC, 2010) and the use of non-formal work based learning (WBL) in the community setting and its use as a model for interprofessional education and learning (IPE and IPL) (Barr et al., 2011). No environment, Bourdieu (1996) suggests, is 'socially neutral' and interactions within it will be affected by numerous influencing factors. I identified three themes which related to these issues which I will explore in this chapter as follows:

The Three themes

- The Construction of the Student Learning Experience
- The Culture of the Student Learning Experience
- The Social Position within the Team

Theme One: The Construction of the Student Learning Experience

As noted above, the different medical and health care teams were brought together under the one roof of the GP Practice in an attempt to enhance CP (DH, 2005; Hudson, 2007). In chapter four, however, I argued that it was what Bourdieu (1996) describes as 'social space' that seemed to have greatest influence on CP rather than the fact that the different teams were all located within the same physical space, or the physical distance between them. In

examining the student experience it seemed that here too the close physical proximity of the different teams did not impact on their exposure to other professions or to CP. When asked what contact they had had with other professionals, one student gave the following response:

“(...) the only contact was just going down to the main surgery and getting keys for a room (...)”

(PRACTICE THREE STN NURSE F)

In exploring this further I attempted to establish whether there had been any exposure to formal CP built into the students' timetables. As I identified in chapters three and four formal, interprofessional, team meetings occurred on a monthly basis in all of the GP Practices. These related both to patient care and interprofessional continuing education initiatives and represented the main, formal, occasions when the different teams met together. In addition I had established that a weekly Practice Management Team Meeting took place between the GPs and the Practice Manager.

During the focus groups, I explored the extent to which the students had been included in any of these meetings. In relation to the medical students it appeared that they had not been involved in any of the meetings:

ME: “Do you sit in on any of the Practice meetings at all?”

F: No

ME: You don't?

M: No

ME: Or any of the Practice education?

M: No”

(PRACTICE THREE MEDICAL STN M&F)

I received a similar response from the nursing students:

ME: “(...) Did you sit in on any of the meetings that they have? Or any of the education sessions that they do?”

F: No. No I didn't"
(PRACTICE ONE STN NURSE F)

Whilst this response was made by a first year nursing student on a short (three week) placement with the health visiting (HV) team I received a similar response from a third year student undertaking a ten week placement with the district nursing (DN) team as the following extract shows:

F: "(...) every Friday lunchtime they had an MDT meeting (...) and there was health visitors and district nurses, community nurses and GPs and practice nurses sometimes but they were really busy so they couldn't come all the time. So there were, I think they did, like power point and they were dealing, talking about the same clients (...)

ME: Were you able to contribute to those?

F: Well not really, actually, but I thought if I went maybe later in my placement I probably could contribute on some things

ME: Right. So you just went the once did you?

F: Yer"
(PRACTICE TWO THIRD YEAR STN NURSE F)

From the responses I received it appeared apparent that the students were generally not coming into contact with the other professional teams: neither through exposure to formal occasions where CP occurred, nor informally through simply being situated within the same physical space. This was despite the different teams being located within close proximity, within the same physical space. I did however identify factors which influenced whether they came into contact with other professions although when it did occur it was not necessarily the primary aim. For medical students the most significant influences appeared to be two-fold: firstly the timing of their placements and secondly; the level of flexibility awarded to the students. As I noted in chapter three the medical students involved in this study were fifth year medical students who were approaching their final examinations. Because of the timing of their placement they described an element of flexibility that was built into their timetables which enabled them to choose whether they attended specific activities and meetings or not. The result of this was that they chose *not* to attend formal activities or meetings where they would otherwise be exposed to CP, as the following extract shows.

Emphasis has been made to key phrases which show how the students considered CP to be an *additional* part of their learning experience rather than an integral element of it:

F: "I think our views are slightly skewed in that, just because of the time of year it is, we have been attending everything that we're supposed to attend but **we haven't spent any extra time** (...) they've got other things here that really sound (...) which I think, if it was a different time of year **when we had more time to give up**, we probably would have maybe done more of that"

(PRACTICE TWO MEDICAL STN F; Emphasis Added)

Therefore when given an element of choice as to what they could participate in it appeared that they did not consider involvement in formal CP to be of sufficient priority for them to 'give up' their time in order to be involved in it. However when asking them to identify when and how different professions would come together in the primary care setting they struggled to respond. Thus their incentive (their 'illusio') to participate in 'the game' appeared to be missing (Bourdieu & Wacquant, 1992; Colley & Guéry, *in print*). This is supported in the following extract whereby they were unable to give examples of when different professions might interact in the primary care setting but unprompted were able to identify when doctors in the hospital environment may do so:

ME: "can you give examples of when you have or when you think you would come into contact with members of the primary care team, outside of the medical profession, in primary care?"

F: Do you mean as medical students

ME: Yer

F: Or as like ...

[PAUSE]

ME: Thinking about the role of the GP I mean you're here to experience GP Practice and the role of the GP and as a medical student in relation to that, what the relationship is with the other professional groups and how they actually work together in primary care

F: Well if you're working on the ward as hospital doctors as we will be next year if you've got patients coming in, if you've got a confused patient come in you might be in contact with the primary care team, be in contact with the patient's GP"

(PRACTICE TWO MEDICAL STN F)

In the previous chapter I concluded that physical presence, as in previous studies, (for example: Jesson & Wilson, 2003) was insufficient in order to attain positive CP in the primary care setting. The responses from the medical students also suggested that it was insufficient in order to achieve neither exposure to CP, nor appreciation of its relevance.

I drew similar conclusions from the nursing students. Whilst there was an element of flexibility built into the medical students' timetable the student nurses' timetable was more prescriptive. As I will discuss later the student nurses' timetable was set by their supervisors/mentor. Despite this, there remained a lack of exposure to, or engagement in, CP. However when students were exposed to, or involved in, activities with other professions the factors that influenced this were unrelated to the recognition of the need to engage in CP, or be exposed to CPs of others. For medical students the influencing factors on their (lack of) exposure to CP appeared to be the timing of their placement and the element of individual choice in the placement experience. For nursing students, however, it was the gender of the student that was the influencing factor with male students having an increased exposure to other professions over their female counterparts as the following extract shows:

M: "I had a slightly different experience from [name of peer] because [name of area], the area that they cover is [name of area] is, is, well all was exclusively Asian, they were looking after exclusively Asian families and, there were a number of families who wouldn't let me through the door, 'cause I was a man (...)

F: So [name of peer] had a different experience

M: I had a very different experience. I had a lot more different, mainly because sometimes I wasn't allowed through the door (...)"

(PRACTICE THREE STN NURSE M & F)

Another male student also identified additional time spent with other professionals based on his gender but as the following extract shows did not consider this as time spent in useful activity:

"ME: "I just want you to start by telling me a little bit about what a day entailed when

you were there. And obviously you're all going to have different experiences but, what did you do when you were there? What was the day like?

M: (...) Being a male student, I think, not much really cause they're dealing with females and babies, so all the clients, um, they're not confident to talk with male nurse

ME: Right. So you had some problems did you being male?

M: Yer, yer, yer"

(PRACTICE TWO STN NURSE M)

The male nursing students I interviewed were first year students on a 'short' placement with the HV. These students recognized that they had had a different placement experience to their female counterparts and identified the rationale for this as being their gender and the reluctance of the predominantly South Asian female client group in the geographical area in which they were based, to prohibit them access into their homes because of this. In describing these 'alternative' experiences, however, these (male) students identified an increased level of time spent with staff from different professions with examples of the alternative activities they engaged in illustrated as follows:

M: "They told me if I can do the erm, work with GP doing minor surgery so I know what I'm doing in the future (...)"

(PRACTICE TWO STN NURSE M)

And:

M: "(...) So, I did find at times, I had a different experience from [name of peer] because I ended up going to work with the, there was a blood group who work exclusively with iron deficiencies in South Asian communities and I went out with the pediatric nurse. Sorry, the pediatric doctor, the pediatrician who works in [name of GP Practice]. And I spent some time also at the surgeries around the area as well, um, in [name of area] and in [name of area]

F: So [name of peer] had a different experience

M: I had a very different experience. I had a lot more different, mainly because sometimes I wasn't allowed through the door"

(PRACTICE THREE STN NURSE M & F)

Whilst these students spent time with other profession(al)s they seemed to consider this to be an alternative and inferior experience offered only because their gender prevented them from entering the homes of the local South Asian women rather than shadowing the HV as they had expected to do on this placement. Due to this I found that they did not consider working with other profession(al)s to be a valued learning experience.

In addition the time spent with other profession(al)s did not involve CP but was simply time spent shadowing them as the following illustrates:

ME: "Yer, yer, so what were you doing when you went out with the, um, pediatrician?"

M: The pediatrician it was basically just her day that she was working

(...)

ME: Right. And you shadowed

F: Yep I shadowed her, and played with the child [laughs]

ME: What about at the blood clinic?

M: Oh at the blood clinic it's um, it's, it's just er small, it's basically the 'drop-tests' for the iron deficiency or taking small, um, taking the blood but with that again it was just shadowing"

(PRACTICE THREE STN NURSE M)

I concluded therefore that students had limited exposure to CP and the factors that influenced this appeared not to be related to the physical presence or proximity of the different professional teams. Furthermore, when exposure to other profession(al)s did occur, students appeared to passively observe the role of the other profession(al) rather than either actively engaging with them or of experiencing different professions working together. Because of this I concluded that students were not provided with opportunities to observe, learn or experience CP skills in this setting.

As I have previously stated Bourdieu (1979; 1985) describes social class as a sharing of tastes and habitus with individuals brought together through a 'space of lifestyles' (Bourdieu, 1985; p730). In this study I found the professional identity of those involved to be significant in drawing people together. Equally, it seemed that there were different views and 'tastes' between the different groups which separated them from each other. In particular there appeared to be a social order evident between the groups which was dependent on lifestyles and 'social capital' held (Witz, 1992). Whilst staff teams verbalized during the focus groups that there was positive CP occurring between the different teams the strength of the 'group' (professional) identity' clearly remained dominant and manifested itself into a (low) level of engagement that was such that students were not exposed to any CP, or aware of it occurring. Equally, it appeared that this same 'group affiliation' also impacted on the students' lack of engagement in CP and to the lack of importance they placed on it.

Despite this lack of exposure to other professions and in particular CP the students confirmed that they believed CP in the primary care setting to be positive. As I discussed in chapter three the focus groups with the students were completed after the analysis of the focus groups with the staff teams had begun. This enabled the questions I asked the students to be adapted following the initial analysis of staff interviews that I carried out. Based on this analysis I added an additional question to the students' focus groups as follows: 'are you aware of any conflict between different members of the Primary Care Team? If so, how was this resolved?' In responding to this question students reported believing CP to be positive in this setting and were unable to provide any examples of conflict between the teams. Because of this I concluded that the students were not exposed to, nor aware of, any conflict taking place and as such believed that it did not occur. However, as I previously identified, students were found to have had minimal exposure to other professions or to any CP during the period they were on placement in the GP Practice. Furthermore, as I identified in chapter four and summarized above, where CP was considered to be poor then this (the poor relationship) was used as a rationale by staff for their not making an effort to engage. In this way it was possible for me to conclude that not only did students experience a lack of exposure to CP generally, but that they were also shielded from exposure to any poor CP in this setting, due to the different teams' lack of engagement where relationships were considered to be poor. It was this lack of exposure to CP, and in particular to poor CP that, I believed, led students to consider CP practice in the primary care setting to be positive.

In addition students' beliefs regarding CP in the primary care setting appeared to be further reinforced by the regular exposure to other professions and conflict between the professions that they experienced in the hospital setting. For example asked if they had seen any conflict in the primary care setting one set of nursing students responded as follows:

F: "No

M: Nope

F: I think there were generally working very closely and very effectively"
(PRACTICE TWO STN NURSE M & F)

Similarly the medical students interviewed also confirmed that they had not seen any interprofessional conflict whilst on placement in the primary care setting as the following extract confirms:

"Not in primary care, no. In hospitals, yes"
(PRACTICE THREE MEDICAL STN M)

Whilst unable to identify any conflict they had observed in the primary care setting students were readily able to identify conflict within the acute hospital setting. When asked to give examples, one group of medical students described the following:

F: "There's little things that happen on the wards like: the physios will be with a patient and the patient needs to go for a test and then you know the doctor needs, wants, the patient to go for a test whereas the physio needs them for another half an hour"

And:

"Yes you'll say they need a CT scan tomorrow and the first available slot they've got is next week and then the radiologist will decline doing a test or whatever"
(PRACTICE TWO MEDICAL STN F)

The medical students also gave further examples describing, specifically, conflict between the doctors and the nurses. Nursing students too were readily able to provide examples of interprofessional conflict in the hospital setting. However, whilst the examples provided by the medical students involved conflict between themselves and all the professions, the examples provided by the nursing students focused only on conflict between themselves and the doctors. The following is one example of the accounts that were given:

"They might be good at aspirating liquid out of a vertebrae but when it comes to

the actual care of the patient they 'aint got a clue I don't think. And, and, and the nurses get frustrated with it"

(PRACTICE THREE STN NURSE F)

I also found that the nursing students gave other examples regarding conflict and the level of 'care' with one student describing how she had attempted to challenge a doctor to act on behalf of a patient who appeared to be in pain and the difficulties she experienced due to, she believed, her own status as a (nursing) student. In recounting this generally, she described the situation as follows:

"(...) nurses work very close with patients so we know (about) making the patients comfortable and sometimes they (doctors) argue with it and yer, compromise each other"

(PRACTICE TWO STN NURSE F)

Whilst the focus of my study was on the primary care setting rather than the hospital the examples of conflict observed or experienced by students in the hospital setting provided me with a greater insight into the contrast between these two environments and therefore how the student made sense of their experience in the primary care setting. From the examples given it appeared that the types of activities undertaken in the hospital setting brought professions into direct contact with others and in doing so they were exposed to potential situations of conflict due to a number of different reasons such as tensions of conflicting priority of time and of needs, as highlighted above. What appeared to be a significant difference between practices in the hospital setting and the community setting, however, was that in this latter environment the roles of the different teams could be carried out without any direct contact with other professions taking place. The result of this was that the students believed that interprofessional conflict did not occur in this setting and therefore that CP relationships were good.

This was confirmed by one of the nursing students who described how he had observed nursing staff in this setting working more autonomously than in the hospital environment and how this was considered a positive attribute. For emphasis I have highlighted in bold the key words and phrases that the student used in the following extract:

"I think the teams are a lot more **autonomous** they work, I think they work, as almost **autonomous units** rather than um. I mean the health visitors seem to be quite **independent** in their decision making they, they, they have a lot of **control**

over their case-load and they can refer on but they don't seem to: **the decisions are made by them** for the care of their um, their ... their caseload"

(PRACTICE THREE STN NURSE M Emphasis Added)

As I argued in chapter four the nursing teams used what I described as 'parallel' linguistics as a mechanism to side-step the dictate of the GP and enable them to work with a greater level of autonomously and avoid potential conflict (Collin et al., 2011). Student nurses were aware of status-related conflict within the hospital setting and equally were aware of its absence in the community setting and directly associated this to the autonomy they observed in the nursing teams: which they considered to be a positive attribute and conducive to positive CP. Bourdieu (1985; 1996), however, has argued that *all* space in a hierarchical society will be hierarchical. The lack of physical distance between the different professions – or classes – in the hospital setting appeared to have brought them together in a way which impacted on their ability to work autonomously. This seems to have created a direct conflict with those who continued to hold a higher social position to themselves (Coombs & Ersser, 2004; Fagin & Gaerlick, 2004, Snelgrove & Hughes, 2000; Vogwill & Reeves 2008). In the primary care setting, however, there appeared to be less contact and more ability for the nurse to work autonomously. Where interaction did occur positive relationships were maintained by either submissively accepting the greater power of the doctor (as with the DN team accepting the GPs wouldn't undertake joint visits as I described in chapter four) or subversively (by not challenging the doctors' use of authoritative, directive, methods of communication (Thylefors, 2011) as I also described in chapter four, but then side-stepping this directive in a non-confrontational manner (Collin et al., 2011).

Student nurses appeared to recognize the social space between the doctors and the nurses (Bourdieu, 1985) but also appreciate the autonomous role of the nurse (Quinlan & Robertson, 2010). As the nurses seemed to have learnt how to work autonomously in the community setting without challenging the hierarchy historically in place between the doctors and nurses, the student nurses did not witness any conflict. As such they believed that there was good CP taking place. However, as I described in chapter four, I found hierarchical relationships still to be in place in this setting but with the nurses having found ways of side-stepping them (Collin, et al., 2011). Therefore what the student nurses appeared to be learning in this setting was how to avoid conflict without challenging the established authority of the doctors (Collin et al., 2011).

Equally I found that the lack of engagement with other professions and consequently the level of time spent in uni-professional practice also appeared to be indoctrinating the students into the epistemological norms of their chosen profession. As I

argued in chapter four, simply bringing people together in one physical space will not necessitate that they will form a cohesive group, or 'class' as there are likely to be symbolic similarities and differences which will draw people together (Bourdieu, 1979). Whilst the GPs and the nurses occupied the same physical space they both experienced it differently due to the differing hierarchical position that each held (Bourdieu, 1985). In addition they continued to spend most of their time with those from their own profession: adopting their characteristics, behaviours and ways of 'being' (D'all Alba, 2009). The physical space, therefore, seemed to become symbolized in the sub-space of the occupants in relation to the (physical) space each occupied: the clothing they wore; the language they use and the practices they carried-out representing "the symbolic expression of class position" (Bourdieu, 1979; p175). People learn how to act in certain ways, depending on their class position. The characteristics and mannerisms of those within a certain 'class' Bourdieu (1996) suggests, will be taken on because they are part of that class, rather than the characteristics and mannerisms bringing people together to form a class. Therefore, the medical and nursing students were socialized into the lifestyle of their qualified counterparts and, pre-reflexively, adopted their characteristics (Chambers & Narayanasamy, 2007; D'all Alba, 2009; Farrell, 2001; Nairn et al., 2012) which became an intrinsic part of their habitus (Bourdieu, 1985).

Theme Two: The Culture of the Student Experience

I found there to be a symbolic representation of the position each student group held which was reflected through the way in which their day was constructed and in particular who was responsible for this. For example, I found there to be a difference between who was responsible for the organization of the medical students' timetable and that of the nurses, and therefore of their experience. As I highlighted in chapter four the tasks that the different professions undertook appeared to reflect their position within the Practice. For example: GPs had menial tasks carried out for them; administrators carried out a number of menial tasks for GPs and; nursing teams carried them out for themselves. Similarly I also found this symbolic distribution of tasks to be reflected in the organization of the students' timetable. Whilst nurses were responsible for the organization of their nursing students' timetables themselves, the GPs had others to do it for them. At Practice Two the Deputy Practice Manager (DPM) was identified as the person responsible for putting together the timetable for the medical students and as the following extracts show also held general responsibility for its co-ordination:

"(The DPM is) involved in organizing the programme (...)"

(PRACTICE TWO ADMIN F)

And:

“(...) I’m just there to support them really”

(PRACTICE TWO DPM F)

However I found that this difference applied not only to the organization of the students’ timetables, but also to its application. GPs had additional time allocated into their daily activities as the following extract shows:

“We do get a bit of extra time booked out, so you get some gaps put in”

(PRACTICE TWO GP F)

Conversely nursing staff did not as the follow extracts show:

F: “The day doesn’t really look any different apart from the fact that you have a student nurse with you you’re not really allocated any different time or anything

(...)

F: They just sort of fit in really”

(PRACTICE ONE PN F)

And:

The same just a bit busier [laughing]”

(PRACTICE THREE DN F)

As I previously stated Bourdieu (1989) argued that physical space will be both viewed and experienced differently depending on the social position of those within it. This different experience is generally “taken for granted” (Bourdieu, 1989; p18) and accepted as normal and as a result a hierarchy is established as people learn a “sense of one’s own place” (Bourdieu, 1989; p17). This certainly appeared to be the case in this study as shown in the examples I provided in chapter four. I also found this to be confirmed further with regards to how their students’ experience was managed. However, whilst nursing teams appeared to be aware of the difference in status between themselves and the GPs they did not seem to be aware of their own culturally adopted behaviours which, I believed, continued to confirm their position in the hierarchy of the GP Practice. As I showed above, for example, nursing staff accepted and took for granted their responsibility for organizing the student experience and of

the additional work involved in supporting students as part of, and on-top of, their everyday roles. Equally GPs seemed to take for granted the fact that the task of organizing their students' timetable and experience would be carried out by others and in supporting students, that their work-load would be adjusted accordingly. This again appeared to reflect the distribution of (menial) tasks in relation to the social position that each profession held.

In the same way these differences also seemed to be accepted by the students who appeared to be conditioned into the social position of their supervisors whilst unquestioningly accepting their status and the social space between the teams that this created (Bourdieu, 1989). As I identified within chapter four Bourdieu (1979) considers class identity to be associated with 'tastes'. Those from the same social class, he argues, will have similar tastes.

What he also highlights, however, is that this taste will not always be through choice, but can also be through necessity: an enforced choice which materializes itself as: "the symbolic expression of class position" (Bourdieu, 1979; p175), which becomes an inherent part of the individual's habitus (Bourdieu, 1996). In this study I found that the time spent by students with their uni-professional teams seemed to further indoctrinate them into these 'tastes' and acceptance of the position that this professional identity created (Bourdieu, 1979). One example of this was that nursing students appeared to accept that their supervisors were busy and that they had to fit into their schedule which left them, at times, with empty gaps in their timetable. Medical students, however, as I identified in my first theme, had an element of flexibility built into their timetables whereby they could choose what they engaged in and what they did not. For medical students these gaps provided them with opportunities to revise for their exams as the following extract shows:

"(...) we've just come in for what we need to come in for and (we're) revising a lot"
(PRACTICE TWO MEDICAL STN F)

Nursing students, however, had their timetable organized fully by their supervisor and had no such flexibility built in. Whilst these students also had gaps in their timetables where they had no formal activities scheduled they didn't see it as an opportunity to revise or study as the medical students did. Instead it seemed to be considered as something that had to be endured. One third year student on a DN placement, for example, described how she would go on visits or attend clinics in the mornings but often found herself with nothing to do in the afternoon whilst the DNs completed their paperwork: an activity nursing students were not permitted to do unsupervised. She described thinking the following:

"They look really busy but I've got nothing to do'. I can ask, 'can I just

document?', but you know I had to wait a little bit until they've slowed down (...) I tried to use that time to study. Usually took my books in, in the afternoon and read"

(PRACTICE TWO STN NURSE F)

Equally first year students on a HV placement reported a similar experience:

"(...) if they were doing their paperwork then I'd do mine"

(PRACTICE THREE STN NURSE F)

Thus both medical and nursing students had gaps in their timetables and each used the gaps to study. The significance of these gaps and study time, however, appeared to be considered differently by the two student groups. For one it was empowering and represented the autonomy they had over their learning experience whilst for the other it represented an encumbrance they were expected to dutifully endure. Indeed, one nursing student described how others complained about times in their days when they were not allocated work to complete. She said:

ME: "Sometimes you were left with nothing to do (...)?"

F: I tried to use that time to study (...). I had a very good time there and some people complained but I really enjoyed it

ME: Complained about what?

F: Doing nothing in the afternoon"

(PRACTICE TWO STN NURSE F)

From this it appeared that the nursing students saw their acceptance of being left without activities to complete as a burden to endure and should be accepted without complaint. By not complaining, this student seemed to be suggesting a positive attribute in herself in her identity as a student nurse, that was not present in her peers. Bourdieu (1979) suggests: "the propensity to subordinate present desires to future desires depends on the extent to which the sacrifice is 'reasonable' that is, on the likelihood, in any case of obtaining future satisfactions superior to those sacrificed" (p180). Considering this in relation to the student nurses in this study it appeared that they believed they would, and indeed should, make sacrifices as part of their journey towards becoming a registered nurse and of an acceptance that this was something they should endure in order to reach their ultimate goal.

This sacrifice also appeared to be true regarding the physical space that they occupied. As for their qualified counterparts the physical space the medical students occupied seemed to reflect their higher status and was superior to that of the nursing students as the following extract from my field notes shows:

"The medical students have their own computer room in the (name of building) where they can sit and study. This room also contained a white board and doubled up as a training room for them as well"

(EXTRACT FROM REFLEXIVE DIARY)

In comparison there was no additional space available for nursing students who had to fit in where there was space available within the rooms already occupied by their supervisors. As the following extracts show, this meant that at times they had to share a desk:

"I hot desked a bit really (...) I didn't mind, you know, keeps someone else's seat warm (...)"

(PRACTICE THREE STN NURSE F)

And:

"I had two different supervisors so I had the desk of the supervisor who wasn't there "

(PRACTICE THREE STN NURSE M)

And thus their social position in the Practice was reflected in the physical space they occupied and mirrored that of their supervisors. Not only was there a lack of physical space for the students the ambiance itself was also not considered to be a high quality as the following extract shows:

"The office was small and so hot"

(PRACTICE TWO STN NURSE F)

As I previously stated Bourdieu (1996) suggests that the physical space an individual occupies will reflect the social position they hold and in chapter four I argued that the physical space occupied by the GPs reflected the difference in status between themselves and the nursing teams. In the same way I found there to be a difference in the physical space

occupied by the two student groups. Whilst the medical students didn't occupy their own private consulting room they did at least have a room specifically allocated for their use. Conversely nursing students didn't even have their own desks but seemed to be accepting of this. Just as the gaps in their timetables appeared to be sacrificially endured by the nursing students, so too did this lack of personal space in which to work (Bourdieu, 1979). Individuals will make sense of their world through the socially constructed position that they hold in it (Bourdieu, 1989). For nursing students this appeared to be a sacrificial endurance which reflected the habitus of their qualified counterparts and further confirmed to me how they were immersed into the subconscious social rules on the use of space that were played out by the staff of the GP Practice. In doing so the students appeared to be indoctrinated into them, accepting them as epistemological norms.

Theme Three: The Social Position within the Team

Both the time spent in uni-professional practice and the acceptance of practices and availability of physical space suggested to me that the students were being indoctrinated into maintaining 'their rank' (Bourdieu 1989; p 17); that is implicitly learning to maintain the social position their qualified counterparts held within the hierarchy of the GP Practice.

As I identified earlier in this chapter the focus groups with the students were carried out after those with the staff groups had been completed, thus enabling me to add questions and amend my interview schedule based on the initial analysis that I completed. As well as asking students about conflict, as discussed earlier in this chapter, I also asked the students whether they considered the primary care team to have a leader and if so who it should be. In asking nursing students this question the following reflected the general response received:

"I think it should be a doctor (...). Well generally, I really do, they're 'doctors' surgeries, that's what I see as a, primary care, that's where it's based and if they're not the boss, who's gonna be? Who's gonna turn round to a doctor and tell em what to do? It's gotta be a doctor hasn't it?

(PRACTICE THREE STN NURSE F)

For nursing students their response suggested an explicit understanding of the hierarchy of the GP Practice and their position within it (Bourdieu, 1989; 1996). For medical students, however, the answer to this question was less clear. Like the nursing students, medical students did consider the leader should be the doctor. However, it is interesting to note how the doctor is described as I highlight in the following quote:

M: "Well I would say, I would have thought the GP would be the person, because if you or I have a problem we'd go to the GP and then **he** involves like a spectrum of people from there

F: Yes it all gets sieved through the GP and then gets sent elsewhere, you know, depending on what their needs are

M: Yep. Yer, I agree with that"

(PRACTICE THREE MEDICAL STNS M & F Emphasis Added)

Note here how the male, medical student describes the doctor as a male (as I've highlighted). As in chapter one I suggested that medicine continues to follow a patriarchal model (Coombs & Ersser 2004), despite the increase in female medical students into the profession (Clarke, 1983; Davis, 2003; Farrell, 2001; Keddy et al., 1986; Kilminster et al., 2007; Piertroni, 1991; Porter, 1992). This places them in a higher social position to that of the nurse (Farrell, 2001; Keddy et al., 1986; Piertroni., 1991; Porter, 1992). However whilst the student nurses emphasized the influential, social position of the GP, the medical students did not: focusing instead on the practical rationale for their positioning of the GP in this position.

For students at Practice Two, however, I found there to be a differing of opinion as to who should be the leader of the primary care team with a rationale, again, provided:

ME: "Do you think there is a leader, an obvious leader, to the primary care team (...)?

Fi: The Practice Manager

ME: Right, right

Fii: I hadn't thought that there appeared to be any particular leader, just more of a team. I hadn't noticed an obvious team leader

Fi: Oh I hadn't here, no

(...)

Fii: But at the meetings that we were in it was just everybody contributing

ME: Right. Do you think there should be a leader?

Fi I think most teams need some sort of co-ordination

ME: Who do you think would be an obvious (person) for it to be?

Fii: I think it depends on who natural leaders are. Like you could say it should be one of the senior GPs but the senior GPs might not have very good leadership skills or they might not be organized or they might be too busy. It might be better coming from someone who had a bit more time to organize it (...) I think maybe it needs to be variable between teams

ME: Right so do you think the key ingredient then is about personal qualities?

Fii: Yes I'd say so"

(PRACTICE TWO MEDICAL STNS F)

Whilst I found there to be differences of opinion between the two groups of medical students as to who the Primary Care Team leader should be, both attempted to provide a rationale to support the person they identified as the leader in terms of the positive attributes they felt they should hold. The most significant difference between these responses and that of the student nurses, I would argue, was the nursing students' explicit identification of the higher hierarchical position that the GP held which justified their identifying them as being the leader. This factor was not raised by the medical students. This was despite doctors increasingly taking on managerial roles as part of their professional duties (Numerato, et al., 2012). In theme one I identified how all the conflict identified in the hospital setting by nursing students related to the doctor-nurse relationship. The identification of the GP as the leader of the team: a position held because of a perceived inability of others to challenge them, further suggested to me a high level of awareness of power differentials by nursing students regarding doctors and nurses generally (Collin et al., 2011; Witz, 1992). No comments were made by medical students to suggest that they were also aware of the different levels of power between the two teams. Bourdieu (1989) suggests that those that are of the higher/highest social status often symbolically refute the existence of social space between themselves and others and thereby continue to benefit from the advantages the higher position brings. Whilst the medical students did not explicitly reject its existence, they also failed to acknowledge it and as such appeared to symbolically deny its existence through their silence (Bourdieu, 1989). Conversely the student nurses appeared to be aware of the

symbolic power of the GPs' position and discussed it openly, whilst also accepting it as the norm.

The habitus of the individual reflects both an appreciation of their own social position and that of others (Bourdieu, 1989). It provides a vision on the world which is influenced by different tastes (Bourdieu, 1979) with these tastes themselves reflecting the social position held (Bourdieu, 1996). These tastes, however, are learnt through conformity: ways of behaving, of communicating and with whom individuals socialize; all of which are influenced by the social position that each holds (Collin et al., 2011). As Bourdieu suggests: 'sets of agents who occupy similar positions and who, being placed in similar conditions and subjected to similar conditionings, have every likelihood of having similar dispositions and interests and therefore of producing similar practices and adopting similar stances' (1996; p725). Thus the habitus both perceives and produces tastes that further reinforces their social position and the social distances between them and other professions, rather than altering it. Thus I concluded that the ways of thinking of the students in this study would be influenced by the social position that each held, which in turn manifested itself in terms of the way each behaved.

Discussion

As I discussed in chapters one and two the introduction of IPE became a pedagogical ideology (Barr, 2002; Barr et al., 2011) aimed at enhancing the quality of patient care (CAIPE, 2002) through the attainment of a 'collaborative practice-ready workforce' (WHO, 2010). However, with limited numbers of students in one location at any given time a non-formal model of work based learning (WBL) has become customarily used as a way to facilitate the development of team working and CP skills in the primary care setting (Moore, 2005). What I found in this study, however, was that it seemed to do neither. As with Jesson & Wilson's (2003) study and the findings I discussed in chapter four: neither being based within the same physical space nor the proximity of the different teams appeared to influence the students' level of engagement. Any engagement that did occur took place through chance meetings in corridors or because of restricted access to patients due to, in particular, the (male) gender of the student nurses. Chance meetings were however limited and organized activities with other professions seemed to be considered as 'alternative' and therefore less valued than those involving the students' own profession.

As I also discussed in chapter two, work-based learning (WBL) is considered a student-centred model (Flanagan et al., 2000; Williams, 2010) which emphasizes the responsibility of the student for managing their own learning (Moore, 2005). I found use of

this type of learning to be evident in the medical students who used the 'gaps' in their timetables in order to take responsibility for their own learning in a way that the nursing students did not. For example, whereas medical students appeared to consider the space in their programme to be empowering, nursing students seemed to see it as time whereby they were being neglected by their busy supervisors. The appropriately considered response to this by a 'good' nursing student then seemed to be that of martyrdom in terms of not complaining and finding 'other' activities to 'fill' time whilst waiting for their supervisors to be available again. Whilst I recognized that the medical students in this study had been students for longer than the nursing students, there is still an expectation that nursing students will be able to work and think independently at the point of qualification (NMC, 2010). As a final year student, therefore, nursing students should be able to take responsibility for their own learning (NMC, 2010). Despite this, it was the final (third) year nursing student who seemed to be the most vociferous regarding the expectations of herself and her peers in relation to their supervisors' time. Therefore, whilst there is a belief that nurses have become more confident and able to speak out (Snelgrove & Hughes, 2000; Porter, 1992), in this study I found that there remained an expectancy of support which suggested to me a continued level of dependence with time alone endured as a burden which they proudly displayed. As Bourdieu (1979) suggests, those with a lower status will generally be aware of their social position within a given hierarchy: 'for some the taste of necessity are worn as 'elective emblems', for others stigmata which they bear in their very bodies' (p178). This appeared to be the case in this study with the nursing students readily accepting the sacrifices they made and appearing to be willing to do so as measurement of being a 'good' student nurse.

I also found the attitudes of the nursing students appeared to reflect those present in their qualified counterparts. For example: qualified nurses seemed to accept they had to fit students into their busy day; nursing students didn't like to bother their mentors even when they, themselves, had nothing to do. Qualified nurses accepted cramped and hot working conditions; nursing students accepted having to share a desk. Conversely the attitudes and behaviour of medical students also appeared to mirror the GPs. Here, however, this reflected a position of autonomy and of status (Thylefors, 2011). GPs, for example, expected time to be allocated into their schedule if they were to supervise a student; medical students saw their 'free' time as empowering them to do work of their own choosing. Equally GPs had their own private consulting rooms whereas medical students had their own training room.

These differences in position and outlook also appeared to identify attitudinal differences between the two student groups. Nursing students, for example, readily articulated issues relating to power and status; medical students did not. The characteristics that the students adopted, therefore, seemed to demonstrate conformity to a certain set of

'tastes' that reflected their professional identity (social class) which became an integral part of their habitus (Bourdieu, 1989). As such a 'sense of one's place' seemed to have been passed onto students and thus perpetuated the power differentials between the different professions.

There also appeared to be a lack of exposure to and time spent with other professions which may also have influenced their attitudes towards other professions and their ability to work collaboratively with them. Despite the differing attitudes towards 'free time', for example, the majority of the medical students' time was organized for them; as was the nursing students'. Whilst students were expected to be responsible for their own learning, in reality the majority of experiences that they were exposed to were selected by others. As such learning was also both influenced and restricted by the choice of experiences which had been selected by others. These selections included little or no time engaging in or observing collaborative practices and where it did take place, it appeared neither to be valued nor considered, in some instances, relevant.

Therefore whilst reflection is considered an important element of the (work based) learning process in the clinical setting, enabling them to apply theory to practice (Nairn et al., 2012), in this study the construction of their learning experience, as suggested above, appeared to limit what they learnt. Equally it seemed to influence how they learnt it (Bourdieu, 1996). Whilst students should be able to develop new understandings of their experiences and change practice through praxis (Nairn et al., 2012) this appeared to be limited by the learning opportunities to which the students were exposed. Equally, however, it appeared often to be limited by the taken-for-granted construction of the learning experience which was perceived to be normative (Bourdieu, 1989) as students were socialized into everyday routines (Chambers & Narayanasamy, 2007; D'all Alba, 2009) resulting in un-reflective, habitual, practice taking place (Goldie, 2012; Nairn et al., 2012). What I found here was that students were submerged into uniprofessional practice: learning their place in the hierarchy of professional relationships which was influenced by the social space evident between the two professions. In relation to the medical students, I found this to result in their not valuing IPE. As it was not built into their timetables; they did not value it. I found this also to be true for the nursing students who seemed to consider that they had been cheated out of a more relevant experience because of their gender and as such considered the time they spent with other professions to be an inferior experience.

For both medical and nursing students, therefore, both spent their placement time in the community setting submerged in uni-professional experiences: and appeared to be the experience that they desired. As I discussed in chapter three individuals are unconsciously conditioned into their social class and the position that they take in society (Bourdieu, 1985).

This becomes symbolically expressed through their tastes which equally reflects the social class into which they become conditioned (Bourdieu, 1979). I found this to be equally true for both the medical students in their final (fifth) year of study as well as first and fifth year nursing students.

It appeared to me, therefore, that there were numerous factors influencing how students engaged in IPE in this setting. One significant influence appeared to be their professional counterparts and how they influenced their learning. Equally, however, the inherent social space between the professions also appeared to influence both how they thought and acted: which had become an intrinsic part of their habitus and therefore their *illusio* (Bourdieu & Wacquant; Colley & Guéry, *in print*). In chapter four I ascertained that the physical space of the primary care setting appeared to perpetuate the inherent issues with regards to social space, power and status on the doctor-nurse relationship. In this chapter I conclude that this also had a similar impact on the students' learning experience.

Chapter Six

Discussion

Extensive reforms to the NHS over the past 15 years have seen significant changes to the organization and infrastructure of primary care. This has meant primary care staff equally having to adjust to significant changes in relation to how they work. GPs have moved from solo to group practices for example and been subject to increased regulation, internal markets, auditing, commissioning and management re-organizations (Hafferty & Light, 1995; Holt, 2008). Introduction of the extended role and the introduction of the NP has also seen changes to the nurses' role with the introduction of increased responsibilities which have arguably made the discreet role of the nurse less distinctive as boundaries between their role and that of the GP have become more blurred (Kilpatrick et al., 2011).

Amidst these changes has been an increased requirement for doctors and nursing staff to work together ever more closely and engage in what has come to be known as 'collaborative practice': despite a lack of clarity as to both its meaning and how it should be achieved (Dickinson & Sullivan, 2014; Lingard et al., 2012). One factor that could arguably influence how and if it is carried out is the setting in which it takes place. Traditional areas of practice such as the operating department have long-since been recognized as areas of hierarchy and conflict (Paloniemi & Collin, 2012). However, different settings will each bring with them different challenges and the housing together of different professions under the one roof of the GP Practice in the primary care setting (Hudson, 2007) could equally, I believed, impact on the way in which doctors and nurses collaborate.

In particular the dominant position of the doctor has been recognised as problematic in achieving effective CP as it impacts on the dynamics of the team (Baker et al., 2011; Haddar & Lingard, 2013; Warmington, 2006). Those who hold the greatest power, for example, tend to construct the reality to which others, with less power and influence, have to conform (Staerbek 2012; Witz, 1992). In relation to nursing practice, this has resulted in a continued influence (by doctors) over the nurses' role as a whole: identifying the level of autonomy nurses are granted and in relation to what (Adamson et al., 1995; Fagin & Garelick, 2004; Farrell, 2001).

At a macro level it has been argued that the model of nursing is based on the principle of 'caring' which continues to hold less status than the medical model of 'curing' (Davies, 2003; Hall, 2005; Piertroni, 1991; Porter, 1992). This has been found to manifest itself in practice in terms of how nurses engage with doctors (Collin et al., 2011; Warmington et al., 2006). Historically, Stein (1967) argued that nurses found subtle ways to instruct

doctors without seemingly having done so. In re-visiting this issue more recently, Stein found that the influence of the doctor's power had become less explicit in relation to the way in which doctors and nurses interacted (Stein et al., 1990).

In this study the doctors were still found to hold a position of authority with the influence of linguistics found to be significant. Bourdieu (1989) argued that language can be used as capital and be symbolic of the social position held. Furthermore, it can also be used as a means of distinguishing the status between different groups (Bourdieu, 1985). This was evident in this study. One particular example was the language they used to talk about others and in particular the titles they used to describe the administrators. GPs, for example, referred to administrators as 'girls'. Conversely however the administrators referred to GPs by their title of 'doctor' and as such, I concluded, titles were used as a form of capital to denote status (Bourdieu, 1985): even in the absence of those about whom the titles referred. In this way, it became a powerful reminder of superior-subservient positions of self and others.

I also found the influence of linguistics to impact on how doctors communicated with others which equally sought to confirm their position. Doctors, it has been argued, have historically been socialized into learning to interact using an authoritative and directive manner (Farrell, 2001) and I also found this to be evident in this study. Equally, however, the nurses also seemed to use linguistics as a means of enabling them to work autonomously without challenging the authority of the doctor. Whereas historically nurses used linguistics in order to support the doctor in their role (Stein, 1967), in this study I found it to have been used in order to support their own position as an autonomous practitioner. Using subtle means of avoiding the direct instructions of doctors, nurses have similarly been found in other studies to have adapted their working practices in the primary care setting in order to gain an autonomous way of working whilst continuing to hold a social position below that of the doctor (Currie & White, 2012). One example of this in my study was the way in which the DNs recognized and accepted GPs as the final decision-makers. Where there were differences of opinion as to ways of practicing (such as joint visiting to patients), the DNs appeared to be aware that it was the GPs who had the final say despite the (negative) impact they considered it to have on their own working practices and the quality of care to the patient. However, where advice was given but physical input not required, the DNs were able to choose whether to accept their advice or if it was unwanted, side-step it subversively, in order to maintain their role as autonomous practitioners. The result of this appeared to be an acceptance of the authority of the GPs whilst maintaining a position as an autonomous practitioner and thus avoid direct conflict. In this latter example this seemed to be proved possible because the DNs were able to carry out their work without being reliant on the direct intervention of the GPs. In the first example they could not and this resulted in their submissive acceptance of their

position in the social hierarchy. Therefore it was evident that although the rules of play had changed, Stein's 'doctor-nurse game' was still being played (Stein, 1967; Stein et al., 1990).

One exception to this related to the Nurse Practitioners (NPs). Whilst they still used linguistics as a means to working autonomously, I found it also to have been used as a form of capital and a way of attempting to elevate their social position in line with that of the doctors. The NPs likened themselves to the GPs in the study: comparing their role to that of the doctors. In addition they used the acquisition of their private consulting room as a form of capital in order to cement this affiliation in a further attempt to inflate their position in line with that of the GPs. However, I found that they continued to look for assurances and confirmation of acceptance from the GPs in relation to their holding an equal social position. This behaviour was not reciprocated and as such, I believed, reflected the difference in status between the two professions: the one already holding a position of high standing and the other attempting to be recognized as such. Bourdieu (1996) argues that social classes emerge out of a 'symbolic' distinction of lifestyles which continue to separate them from others. Whilst the NP held additional capital in terms of a private consulting room and additional academic credentials in comparison to her nursing colleagues (Bourdieu, 1996) she remained, primarily, a nurse. Bourdieu (1979) suggests that there are some characteristics that are 'binary', meaning that if someone has one characteristic, it prevents them from holding another. One example of this is being male or female. In this study I found the same principle to apply to doctors and nurses. Much of what was learnt as part of 'becoming' a professional inextricably shaped who they became (D'all Alba, 2009; Nairn et al., 2012). Therefore, whilst the NPs attempted to be 'as' a GP, their very disposition had been created through their social history as a nurse which set them apart from the GPs in a way that could not be transcended (Bourdieu, 1979).

Witz (1992) uses the concept of boundary work to describe how those in positions of power encircle activities over which they have discreet authority. Whilst the role of the NP included elements of the medical role, the central 'core' aspects of the medical role remained distinct and therefore allusive. Kilpatrick et al. (2011) in their study of NPs found that their extended role acted also as a further means of 'protecting' doctors from other staff: with the NP taking on the role of advice-giver to other, more junior, staff. In this way the role of the NP acted as a means of increasing the social space between the GPs and the remaining staff, rather than as a means of bridging a professional divide.

Although not directly included in this study the poor relationship with the midwives became a common theme within my study. Although distance in terms of physical space was identified as an issue by participants, it was the 'playing of the game' that was considered to

have direct influence on the lack of engagement (and distance) with the midwives. Bourdieu describes life as a 'game' with subtle but set laws that are adhered to by those involved in it (Bourdieu & Wacquant, 1992; Bourdieu, 1990). Even when conflict takes place, these tend to occur within the rules of the game that have been set (Bourdieu & Wacquant, 1992). However, there are occasions when participants opt out of the game, refusing to be a part of it any more (Charlesworth, 2000). In considering what was happening in this study it appeared that this was what was taking place with regards to the midwifery service as a whole. The nurses continued to work with the doctors: working around them when need be in order to practice autonomously or accepting the doctors' authority over their own if it was felt this could not be changed within the rules of the game. Conversely, the midwives appeared to have opted out of the game. Unlike the nurses, midwives did not need to negotiate with the doctors in order to carry out their role, but could practice autonomously, irrespective of the authority of the doctor. Thus nurses appeared to have retained their 'illusio': their motivation in order to continue playing the game (Bourdieu & Wacquant, 1992; Colley & Guéry *in print*) whereas the midwives did not. However: the achievement of this autonomy appeared to come at a price. Whereas the nurses worked collaboratively, but with less power and status than the GPs, the midwives seemed to work in isolation.

There appeared also to be a 'distinction of lifestyles' between the different professions, including the NPs, which separated them. This distinction was evident, as described above, in the way in which each interacted with and talked about each other. This distinction then manifested itself into a social space between the different professions which created a social order influencing how, when and if interactions occurred (Bourdieu, 1985; 1996) which was often hidden behind the way in which physical space was used within the Practice. Therefore, whilst the different professions believed that the physical space (and geographical distance) between them had a direct impact on positive relationships (and therefore CP), it appeared that in reality that it was the social space between them which influenced how and if they interacted. Social space Bourdieu argues 'is an invisible set of relationships which tends to retranslate itself (...) into physical space in the form of a distributional arrangement of agents and properties' (Bourdieu 1996; p12). At one level the social space between the different teams manifested itself in terms of the physical space each occupied within the GP Practice. GPs, having the highest status, occupied the symbolically most prestigious physical space: the private consulting room. In comparison the nurses shared an office space and the administrators occupied an open-plan office area. As such the physical space occupied represented the social position held. At another level however I found that the GPs were the least accessible of the professions and that this was reinforced symbolically, as well as visibly, by the (closed) consulting room door acting as a physical barrier to others. The visible manifestation of the physical space occupied also acted to

provide either a restriction to access or to facilitate it, dependent on the social position held. For example: GPs had no time set aside during their working day for them to be accessed by others. In contrast the administrators were most accessible which was reflected both literally and symbolically by the lack of any tangible barriers. Therefore, whilst I found doctors to have contact with the administrators, this tended to be at their (the GPs') instigation and control.

This distinction of lifestyles was also evident in the daily routines of the administrators and the GPs: making one readily accessible and the other inaccessible. As I identified earlier the administrators took on a role that was readily acknowledged by themselves to be subservient to that of the GPs: their duties including completing menial tasks for the GPs. In contrast, the GPs did not carry out menial tasks but had these completed for them: reflecting the higher status that they held. Whilst the tasks themselves reflected the difference in status, it was the relationship between these two professions that I found to be particularly significant. Although the administrators carried-out the menial, less valued, tasks, it therefore meant that the GPs were relieved of doing so and could continue to undertake roles that held greater capital. Therefore not only did the undertaking of menial tasks seem to reflect the lower social position of the administrators, but the role of the administrators itself appeared to serve to sustain the senior position of the GPs and became a further form of capital (Bourdieu, 1985; Davis, 1992).

As a result I concluded that there remained a hierarchy of practice that influenced how, when and if the different professions interacted and that this mostly occurred through implicit, taken-for-granted, behaviours (Nairn et al., 2012) which were an integral part of the habitus (Bourdieu, 1990; 1992; Wacquant, 1992). In particular, the aim of enhancing CP by housing the different professions together under the one roof of the GP Practice (DH 2005, Hudson 2007) appeared to be flawed. The very way in which the physical space was divided for example, created a representation of the hierarchy that it was attempting to eradicate and acted, I believed, to sustain it.

The taken-for-granted behaviours of the different professions therefore reflected the profession they represented and their social position within the Practice, without an awareness of this occurring. Even with the increased status of the NP, their attempt to acquire equal standing with the GPs remained elusive and, it could be argued, served to restrict access to the GPs still further, thereby acting to increase the social space between the GPs and the nursing teams rather than decrease it (Kilpatrick et al., 2011).

In relation to IPE, its growth and establishment within higher education institutions appears to be directly related to the development of CP. Unlike CP, IPE has a single definition

commonly used in order to describe it: "interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 2002). However, the lack of clarity with regards to the meaning of CP makes the evaluation of IPE outcomes challenging (Reeves et al., 2010).

In terms of IPE processes here too there is evidence of continuing difficulties in delivery, impeded by organizational difficulties made challenging often by the number of students involved and restrictions on resources (Pollard et al., 2014). In the primary care setting the use of work-based learning (WBL) is frequently used as a means of delivering IPE (Barr et al., 2011) and here too I found tensions to be evident. This model requires students to draw on experiences learnt in the classroom and contextualise these into relevant skill development in the clinical environment (Williams, 2010). However, the official 'criteria' laid-down by WBL is often masked by 'hidden' criteria – a social expectation of compliance to the hierarchical position held (Billet, 2001a; 2004). In this study when students undertook practical placements in this field, they were immersed into the culture of their qualified counterparts and appeared to be accepting of it and their own position within the hierarchy of the Practice, as the norm. In particular, the nursing students were frequently aware of their qualified counterparts 'making do'. Students, for example, were fitted into their day with no concessions made in terms of workload to support these students. Being exposed to this, nursing students seemingly took on this identity as part of their habitus: accepting it unquestioningly (Bourdieu, 1979). Equally, the culture to which the medical students were immersed also appeared to be accepted as the norm. However, whilst the identity of the nursing students was one of making do and accepting of their 'lot', the identity of the medical students was one of autonomy, authority and capital. Therefore, the students were conditioned into adopting the characteristics of their qualified counterparts (Bourdieu, 1985).

The introduction of IPE was brought about in order to enhance CP and provide high-quality care (CAIPE, 2002; WHO, 2010). The use of non-formal WBL in the primary care setting has been used as a means to over-coming the lack of students from other professions available in order to engage in teacher-led IPE initiatives in this setting (Barr et al., 2011). What was evident in this study was that the over-riding goals of IPE were not being achieved. As I previously stated, the World Health Organisation (WHO) identified six objectives for IPE, one of which is being to work collaboratively (WHO, 2010). However, students spent much of their time in this setting in uni-professional practices. Despite the different professions being housed under the one roof, I found there to be limited evidence of CP and that which did take place occurred mostly without the students' involvement. Those that did spend time with other professions did so because of their gender (being male) and therefore being refused entry into some of the homes of the South Asian women the health visitors (their mentors)

were planning to visit. As such it was seen by the students as an 'alternative' and inferior experience rather than an integral part of their primary care experience. Thus students were neither able to experience 'working collaboratively' (WHO, 2010) nor observe it taking place.

This lack of exposure to CP meant that students were also not exposed to any conflict. In contrast to traditional settings such as the operating theatre where evidence of conflict is high (Baker et al., 2011; Haddara & Lingard, 2013) students reported no evidence of having seen conflict occur between the professions in the primary care setting. However, the nurses in this setting tended to work autonomously and were therefore able to carry out their everyday roles generally without engagement with the GPs. This lack of contact was mistaken by students to be a lack of conflict. Much of what has been written about conflict suggests that it is explicit and recognized by those involved who are able to articulate the difficulties faced. However, in this study not only was there a lack of contact between the nurses and the doctors, I found the nurses to have used subversive and submissive linguistics in order to side-step the doctor's authority and as such avoid any conflict that may have occurred. The result of these implicit, avoidance, strategies was that there was a general *appearance* of positive collaboration which the nursing students seemed to confuse as positive CP. Undoubtedly, professionals did not consciously recognize the strategies being used and as a result, the students did not either. As highlighted in chapter two, learning can take various forms and does not necessitate vertical guidance taking place (Guile, 2011). The actual 'processes' of becoming a professional, therefore, can often remain invisible to the learner, resulting in their failing to recognize those epistemological influences on how knowledge is constructed and contextualized (Gleeson, 2010; Witman et al., 2010). As stated above, much of the student's experiences appeared to be learnt pre-reflexively (Nairn et al., 2012). Therefore the characteristics, behaviours and identity of their qualified counterparts became embodied and an integral part of their habitus (Bourdieu & Wacquant, 1992). This appeared to be a significant factor with regards to their learning experiences as students implicitly learnt to conform to the norms of the profession to which they aspired (Hall, 2005; Nairn et al., 2012).

Conclusions Drawn: An Identification of How the Study Answered my Original Research Questions and Overall Aim

At the outset of this study I aimed to critically analyze the processes and conclusions reached when attempting to explore collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting and set three questions as follows:

- How do participants from varying professional backgrounds (principally doctors and

nurses) experience their relationships with others in primary care?

- What factors (such as status and organizational infrastructures) impact on the way in which doctors and nurses collaborate in the primary care setting?
- What factors impact on the use of non-formal interprofessional education with medical and nursing students in the primary care setting?

In answering these questions I identified six themes as follows:

- Physical Space and Collaborative Practice
- Making an Effort to Engage
- The Social and Physical Space Relationship
- Social Positions and Collaborative Practice
- The Construction of the Student Learning Experience
- The Culture of the Student Learning Experience
- The Social Position within the Team

In doing so I argued that the first three themes (discussed in chapter four) addressed questions one and two and the last three (discussed in chapter five), the final question.

Whilst I have attempted to answer these questions in detail in chapters four and five, I draw on selected illustrations from these chapters in order to demonstrate, here, how the findings from my study answer my research questions and therefore addressed my overall aim. In chapter four, for example, I discussed how staff experienced their relationships with others in a taken-for-granted way. Bourdieu (1985), I argued, describes the disposition of the individual in terms of their habitus. This shapes their identity and how they think, act and behave. This habitus, I argued, inextricably binds them to their peers through a learnt set of tastes (Bourdieu, 1979). In the same way the habitus influences how they engage with others (question one) through an adherence to a set of unwritten rules that is an inherent part of their habitus (Bourdieu 1985).

Indeed, much of what I presented in chapter four related to the experience of their relationships. I discussed, for example, Bourdieu's concept of 'the game' (Bourdieu, 1990; Bourdieu & Wacquant, 1992) whereby those within a given field will interact in such a way as to confirm that they have 'brought into' the game. And, even when conflict occurs, that this continues to be dealt with within the rules of the game which are set.

In attempting to understand these rules and how the 'game' was played out, I examined the factors that impacted on the way in which the doctors and nurses collaborated in the field (question two). In doing so I identified a number of power-related influences that illustrated a hierarchy of positions evident within the GP Practice. Examples I gave included: the accessibility of administrators and nurses and the inaccessibility of the GPs; the titles used to describe different professional groups; the tasks each carried out and; the physical space each occupied. In particular, the way in which the different professions talked and communicated with each other illustrated clearly their different hierarchical positions. One example I provided related to the NP who attempted to usurp (Witz, 1992) her position by emulating the GPs and in doing so seek approval from them in a way which was not reciprocated. However this very act, I argued, continued to set them apart (and below the GPs) in terms of hierarchy. Indeed, their habitus meant that they were unable to cast-off their indoctrinated ways of 'being' a nurse, despite their attempts to elevate their status through disassociation from their nursing peers.

In chapter one I presented an historical, sociological, history of medical and nursing history and argued that this continued to impact on the relationships of the different professions. I also identified how Government policy-drivers cemented the principle of collaborative practice (Dickinson & Sullivan, 2014; Lingard et al., 2012) but that there remained an absence of a clearly understood definition as to what it means (Dickinson & Sullivan, 2014; King et al., 2013; Lingard et al., 2012; Reeves et al., 2011; Trojan et al., 2009). Because of this, I argued, it appeared that social policy ignored the challenges that CP entailed focusing, instead, on the ideal (Warmington et al., 2004). In considering these (organizational) influences on relationships in the primary care setting (questions one and two) it meant (at a simplest level) the coming together of different professions under the one roof of the GP Practice (DH, 2000; DH, 2005; Hudson, 2007). In relation to my study I argued that physical presence and proximity was perceived to be significant in terms of maintaining positive relationships. However in exploring this in greater depth I found that relationships were complex and it appeared that the way professions experienced their relationships created and sustained hierarchical relationships, rather than eradicated them.

With regards to the students' experience I found them to have limited contact with other professions in the field and instead, spent time predominantly with their own profession.

The result of this was their socialization into the lifestyles of their qualified counterparts, whereby their characteristics were learnt and adopted; becoming part of their habitus in a pre-reflexive way. This lack of time spent with other professions, alongside the time spent with their own profession, appeared to have a significant impact on how and what they learnt in the primary care setting (question three). Medical students, for example, embraced unstructured time in their timetables: using it in order to revise. Nursing students, conversely, saw unstructured time as gaps in their day whereby they had to find activities in order to fill it. Nursing students also seemed to be aware of their hierarchical position in relation to the GPs and clearly articulated this in terms of who they saw as being the leader of the primary care team and in how they interacted with doctors generally. Conversely, medical students failed to acknowledge any perceived hierarchical issues. The result, I concluded, was that the current way in which non-formal interprofessional education was used was ineffective. Students failed to value time spent with other professions and spent limited time doing so. For nursing students in particular, it was used as an alternative experience for male students who were unable to enter the homes of the predominantly South Asian and female patients. Instead, students spent time, predominantly, in uni-professional practice becoming indoctrinated into the established tastes of their qualified counterparts.

In addressing my study aim, therefore, I reached the conclusion that interprofessional relationships are complex and influenced by a variety of factors: many of which are historical and ingrained into the very being (the habitus) of professionals. In addition, that the current way in which non-formal education is used appears to further perpetuate this rather than alter it. I offer further conclusions and recommendations for key stakeholders in the final section of this chapter.

Critical Reflection on the Research Process

As part of my conclusion I offer here a critical reflection on the research processes carried out. However, much of the detail provided is explored in-depth within the methodology chapter itself. As such, I acknowledge that the reflection offered is limited: and refer the reader back to the methodology chapter as relevant.

In this study I undertook to complete a critical ethnography which aimed to explore collaborative practice and non-formal interprofessional education by medical and nursing students in the primary care setting. I included three GP Practices in my study as well as the doctors, nurses and administrative teams that were based there. In addition I included medical and nursing students who, in the case of the medical students, were currently on placement at one of the GP Practices and with the nursing students, had been on placement there at some point in the previous 12 months.

The Practices included in the study were chosen purposively although I included criteria to help me in the selection process which is laid out in Table One in chapter three. The methods I used were focus groups, observations, field notes and the keeping of a reflexive diary. I then carried out my analysis inductively, using template analysis as a framework and the software NVIVO8 as a means to aiding the organisation of the data. Finally I presented my findings in terms of themes identified and have attempted to show, through examples taken from my reflexive diary, how these findings were reached.

Whilst I could have used a number of different methodologies I believe the use of critical ethnography was appropriate for the type of study undertaken. Having chosen to carry out a study which was inductive in nature it was important for me to select a methodology that met the criteria for this type of qualitative approach. That is: it attempted to gain understanding of the culture of a given field and context within which participants experience it (Angrosino & Mays de Perès, 2003; Sarantakos, 2013). The particular methodology chosen should then reflect the theoretical lens the researcher chooses to use. As I believed I would be entering a field where the historically dominant position of the doctor could negatively impact on the working and learning experiences of others with whom they shared their physical space I considered critical ethnography an appropriate approach: as its aim is to explore and make visible hidden agendas and cultural influences of authority: whilst giving a voice to those being studied (Baumbusch, 2011; Foley & Valenzuela, 2005; Madison, 2012) Similarly Bourdieu's theory of social life (Bourdieu, 1979) attempts to provide theory by which sense can be made of power within social relationships. Both, therefore, appeared to complement each other and the focus of the study I was attempting to undertake.

Undertaking an ethnographic approach generally means going out into the 'field' in order to observe participants in their natural environment with tools selected which are conducive to this (Fetterman, 2012). Emerging from an anthropological inception (Holmes & Marcus, 2005) the traditional method of data collection has historically been through observation and extensive periods spent within a given field with some (for example Delamont, 2007) suggesting this should still be the case. Others (for example Fetterman, 2012), however, argue that the 'ethnographic' interview is now the main tool used for gathering data. As I discussed in chapter three, my opportunities to undertake observations in my chosen field were limited due to the confidential nature of much of the work that was being carried out by the doctors and nurses who were acting as participants. And: as the focus of my study was on the relationships conducted between professionals and the interprofessional education opportunities afforded to students I equally decided that the potential benefits of doing so did not outweigh the need to breach the privacy and confidentiality of the patient-professional relationship (Sarantakos, 1998).

The ethnographic interview is described as one which focuses on the culture being studied (Delamont, 2007). Carrying out focus groups therefore enabled me to achieve this purpose through the questions I selected to ask. As I identified in chapter three, I took the decision to carry-out the focus groups uni-professionally in order to ensure those from the non-medical (and therefore arguably dominated) groups, would feel they had a voice without the potentially authoritative figure of the GP stifling their ability to speak (Mcnaghten & Myers, 2007). Choosing to do so, however, left me on occasions with limited numbers of participants available and in relation to the practice nurses in particular, the opportunity only to interview one out of the three groups. I provided a schedule of focus groups completed in Table Two in the methodology chapter (chapter three). However, whilst I did find myself restricted at times in terms of the numbers of participants, the aim of qualitative studies is to reach the point of saturation: i.e. to have obtained the information required (Sarantakos, 1998). Using a selection of methods (i.e.: focus groups, interviews, observations, field notes and a reflexive diary) therefore enabled me to explore the field until, I believed, I had reached this point.

The sample for my study was selected purposively in order to ensure it met the criteria for the study (Sarantakos, 1998). In terms of participants, most were unknown to me prior to the study. However, the nursing students came from the university where I was affiliated and there was therefore a risk that I had previously, and certainly would in the future, have involvement with them. Insider research is now a commonly used approach (Allen, 2004) and brings with it both strengths and weaknesses. It can, for example, enable the researcher to have a prior understanding of the working practices of a given field. Conversely, however, it can also reduce the ability of the researcher to make sense of what is going on (Bonner &

Tolhurst, 2002). Equally, due to the difference in power relationships between myself and the nursing students, it could also reduce their ability to feel that their participation was 'voluntary' (Sarantakos, 2013). To address these issues I kept a reflexive diary throughout and attempted, as far as I was able, to distance myself from the students prior to their involvement, in order to help reduce any feelings they may have of being coerced. One way in which I attempted to achieve this was by sending requests out via email, for example, and another was by ensuring students were able to withdraw without reproach at any time.

Similarly, contact with staff within the GP Practices was made via the Practice Manager rather than myself in order to reduce staff feeling pressurized to participate. Whilst I didn't know any of the staff involved, being asked to participate in any study needs to be fully voluntary (Delamont, 2007). As with the student nurses, I also offered the qualified staff a cooling-off period. This seemed to work effectively and as I stated previously, not all staff agreed to participate. Two groups of practice nurses, for example, declined due to staffing issues and one group of health visitors also elected not to take part.

All research is time limited and mine was no exception (Creswell, 2007). Thus whilst attempting to reach saturation with my data, I also had to achieve this within a certain time-scale. Having received ethical approval to proceed in late spring I had only until the end of the summer to interview the medical students prior to their finishing to take their final exams. As there would then be a gap of a number of months prior to the next group commencing, it was therefore important for me to organize the focus groups as expediently as I was able. In addition, medical students undertook just four week placements in the GP Practices and I wanted them to have completed as much of that time as possible prior to being interviewed, in order to ensure they had sufficient experiences to draw on to participate. This meant there was only a limited period in which I could undertake the focus groups. For those at Practice One, it resulted in my not being able to interview them due to their conflicting commitments.

With nursing students there were no students on placement during the time I had 'in the field' (Delamont, 2007). Neither was there going to be for some months afterwards. This led me to make the decision to include nursing students who had been on placement at one of the Practices in the 12 months previously. Gaining access to participants can be challenging in qualitative research (Sarantakos, 2013) and whilst this meant that the inclusion criteria for the nursing students was different to that of the medical students I felt the most important criteria to be access to students; which therefore justified this decision.

In attempting to make sense of my findings I ensured I wrote field notes either at the time or shortly after my entering the field. Equally I kept a reflexive diary throughout which enabled me to return to observations I had made which did not necessarily have meaning at

the time (Denzin & Lincoln, 1998). Similarly I attempted to type up my interview transcripts expediently which also enabled me to compare what I heard from the audio recordings taken at the time with any notes I had made regarding interactions at the time (Fern, 2001). However, typing up transcripts is time-consuming (Sarantakos, 1998) and, as I was undertaking the research alongside my full-time job, I was not always able to complete this task as quickly as I would have liked. This meant at times there were comments from the audio recordings that were inaudible and, due to the length of time that had passed, meant I was unable to recall the context of what had been said. Inaudibility was made harder with one of the earliest interviews I made too due to both the (noisy) physical environment in which it took place as well as the participants talking over each other at times. As I gained experience and confidence in my role as a researcher, therefore, I took to asking in advance to ensure the environment allocated was conducive to the focus group taking place and asked participants at the outset to only speak one at a time.

In typing up my transcripts as soon as I was able meant that I could begin to analysis my data prior to it all being gathered. This allowed me to alter questions as new insights were made (Denzin & Lincoln, 1998). For example, I added a question regarding the relationship with the midwives as well as asking the students about any conflict they may or may not have observed whilst on placement.

In attempting to make sense of the data as a whole I used the framework 'template analysis' (King, 1998; 2004) and the software package NVIVO8 in order to help with the organizing of the data. Continually referring back to my data, and in particular my reflexive diary, enabled me to make tentative and ongoing hypothesis as I proceeded through the process, which I was then able to test out: confirming or rejecting these as appropriate. I also used my reflexive diary, continually, as a means of helping me to both make sense of my findings and provide evidence as to what I did in order to demonstrate both what I did as well as how I came to the conclusions I made.

Whilst I acknowledge there were limitations to the study itself, all research will have limitations (Sarantakos, 2013). And, as I hope is evident from what I have written here and within chapter three, did not prevent me from making sense of my field.

Conclusion

Whilst there have been a number of initiatives introduced in order to enhance CP at national level, the findings from this study showed that they have been ineffective in achieving their goal. In particular the status and powerful position of the doctor seemed not only to infiltrate all interactions, but also restricted most from taking place except at their initiation. The Government has attempted to create a flatter, team based approach to care (DH 2000, Donetto, 2010). However, whilst a hierarchy of positions remains, what this study seems to show was that it could not be achieved.

It must be acknowledged that the Government has attempted to re-dress the power differentials of doctors to some extent. One example of this is the creation of the extended role and in relation to this study, the NP (DH, 2000). Another similar example involves the move of pre-registration programmes into the university setting. Bourdieu (1990) recognizes the weight of capital as power and educational credentials can be influential in gaining this (Bourdieu & Wacquant 1992). However, capital is not a static form: rather it should be considered as a constantly changing phenomenon (Bourdieu & Wacquant, 1992). As a commodity becomes increasingly accessible, the less weight it holds as capital. As the number of individuals attaining higher academic qualifications rises, for example, the less value that qualification holds (Bourdieu, 1992). Its use as a means to nurses attaining equal status with doctors therefore, is unlikely to be successful.

IPE has also been introduced as a means of breaking down barriers and therefore hierarchy between the professions (CAIPE, 2002; WHO, 2010). However, when used within a model of WBL, as in this study, it was also found to be ineffective in achieving its goal. Furthermore, if current organizational practices continue in their existing state, it is likely that this will continue to be the case. In particular, the essence of nursing as a 'caring' profession is one of lower status to that of medicine (Davies, 2003; Porter, 1992). NPs attempted to inflate their status by distancing themselves from this disposition and take on instead, the attributes of a medical model of curing (Piertroni, 1991). Despite this, their binary disposition of being a nurse meant that they were unsuccessful in achieving this. In order to re-dress the power balance therefore, it will be necessary for the principles of nursing to be appreciated more highly and therefore hold greater capital. Attempts to achieve this at grass-roots level, is likely to achieve only limited success. Attempts by nurses to associate themselves with the medical model, as with the NPs in this study, is likely to bring failure. Making nursing students aware of their indoctrination into the existing ways of being (D'all Alba, 2009) may enable them to change the way in which they engage with doctors. However, whilst medical students

continue to deny the existence of the powerful position of the doctor as 'leader' of the primary care team, it is likely that their success in addressing the power balance will be limited.

However: Bourdieu (1990) describes the field as a constant struggle between those who hold the power and those who challenge it. In this study it was evident that the doctors continued to win this struggle and as such maintained their position of authority. Addressing this appears complex and influenced by a multitude of inter-related factors and as such unlikely to be changed simply by placing the onus on those within the field to do so.

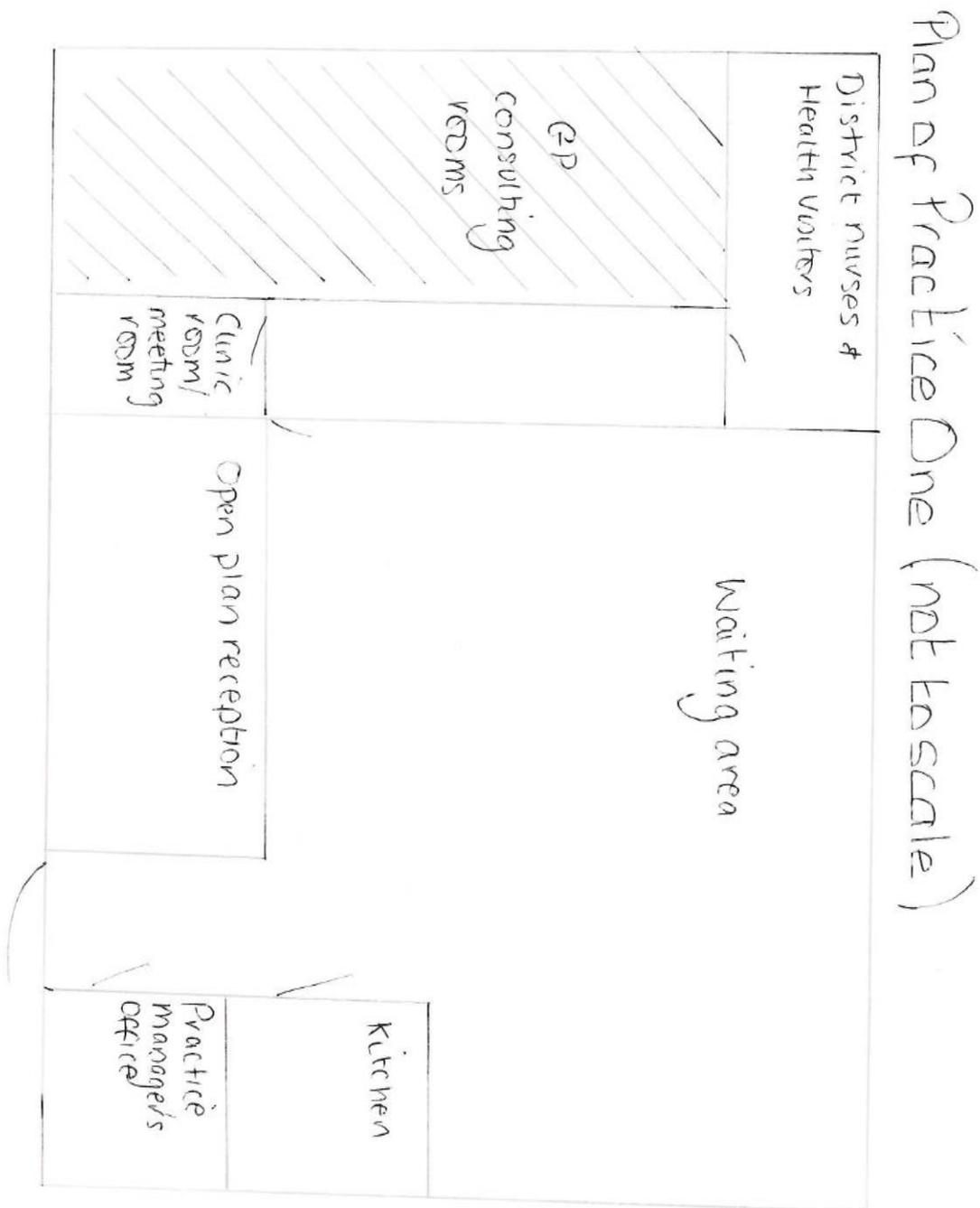
Recommendations and Implications for Practice

Based on the results of this study I therefore make three recommendations for key stakeholders as follows:

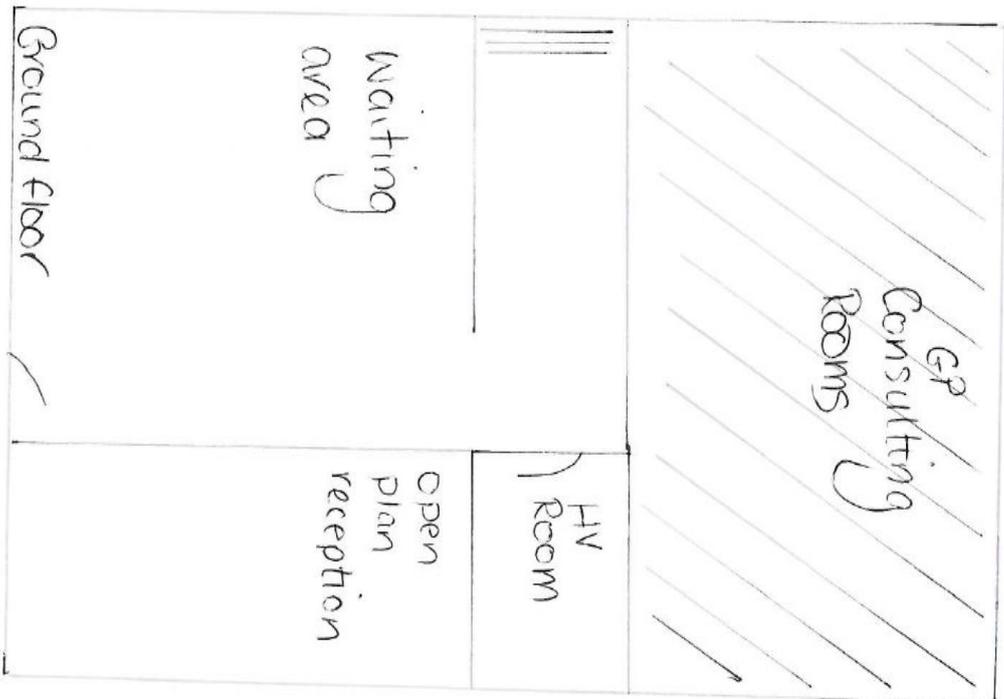
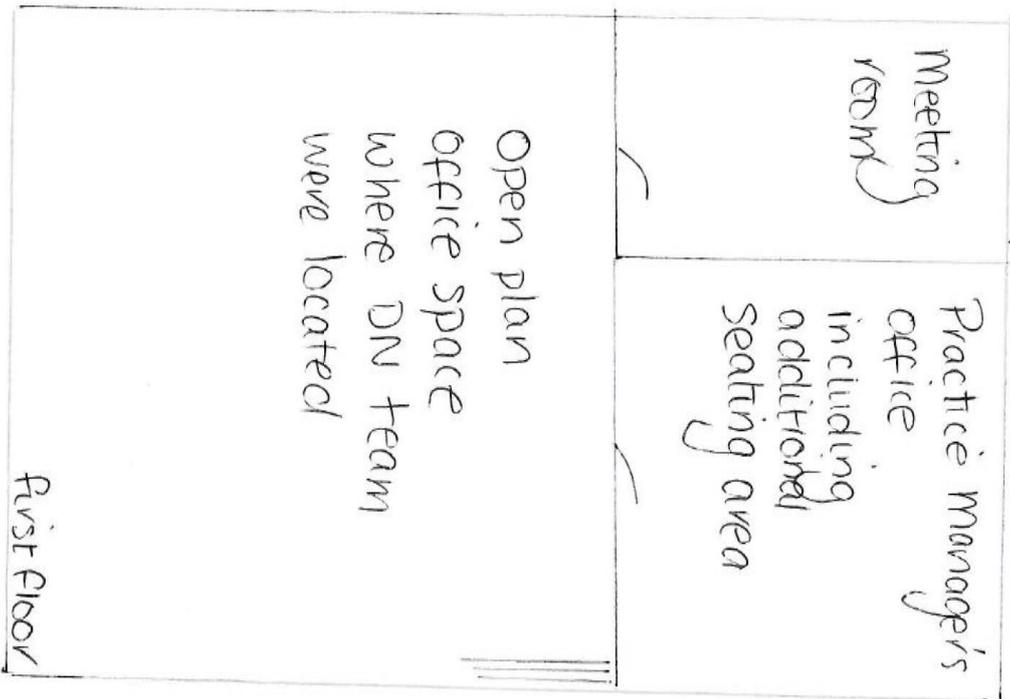
- That pre-registration nursing curricula place an increased focus on communication skills and styles of communication, including assertiveness and decision-making. In particular, there is a need for guidance and support to be put in place in order to facilitate student nurses' recognition of the impact of cultural influences on communication used, both in themselves and in others.
- That there is a need for nurses to embrace their own identities as nurses, rather than attempting to achieve it through emulating doctors and socially distancing themselves from more junior nursing staff.
- That nurses become more involved in advisory roles at Government and Regulatory Body level in order to influence policy. Through involvement in advisory positions, it is possible that nurses will have greater influence and potentially re-dress the balance of power given to doctors in relation to the organization and infrastructures of health care practice.

Appendix One

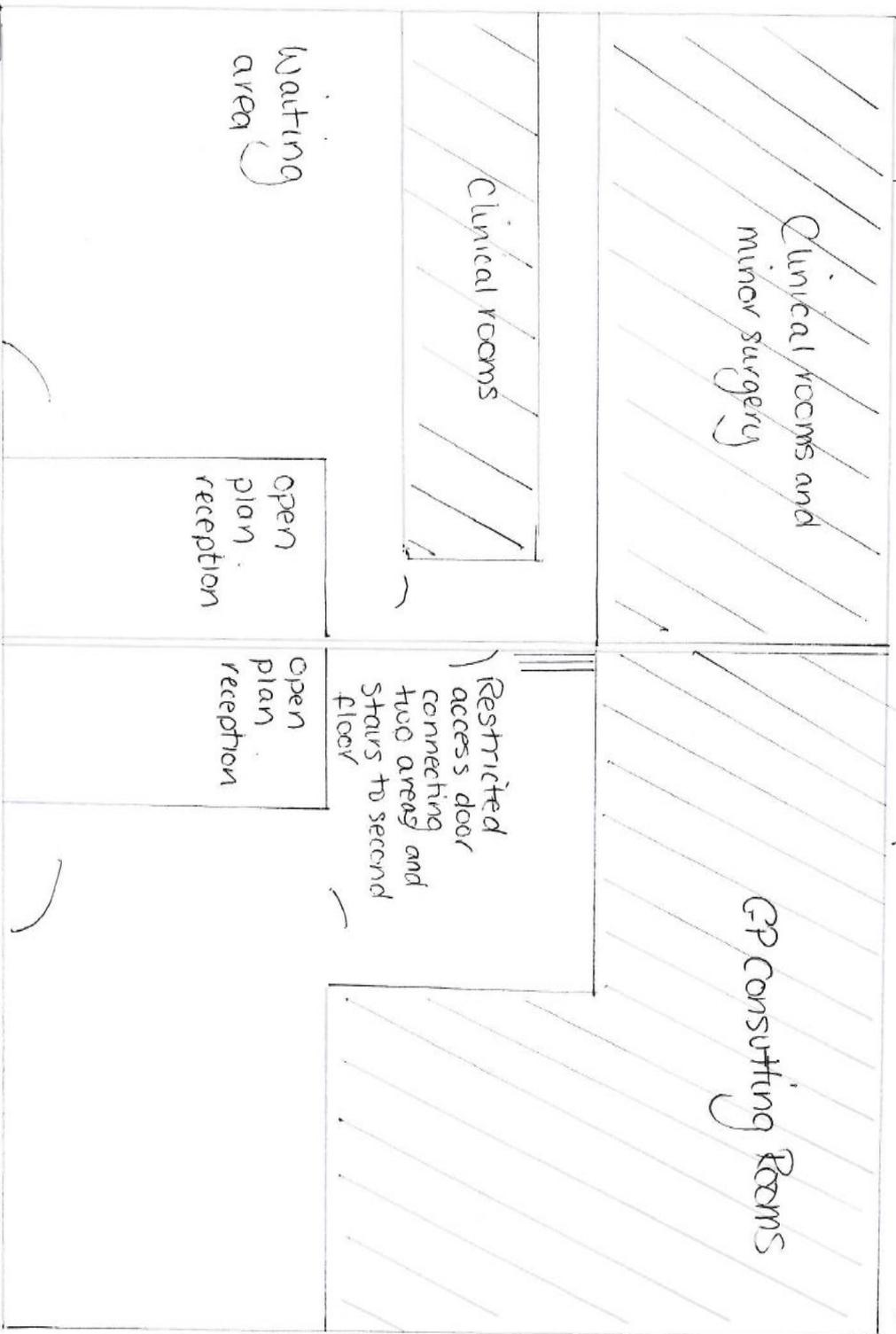
An outline of the floor plan of each of the GP Practices included in the study



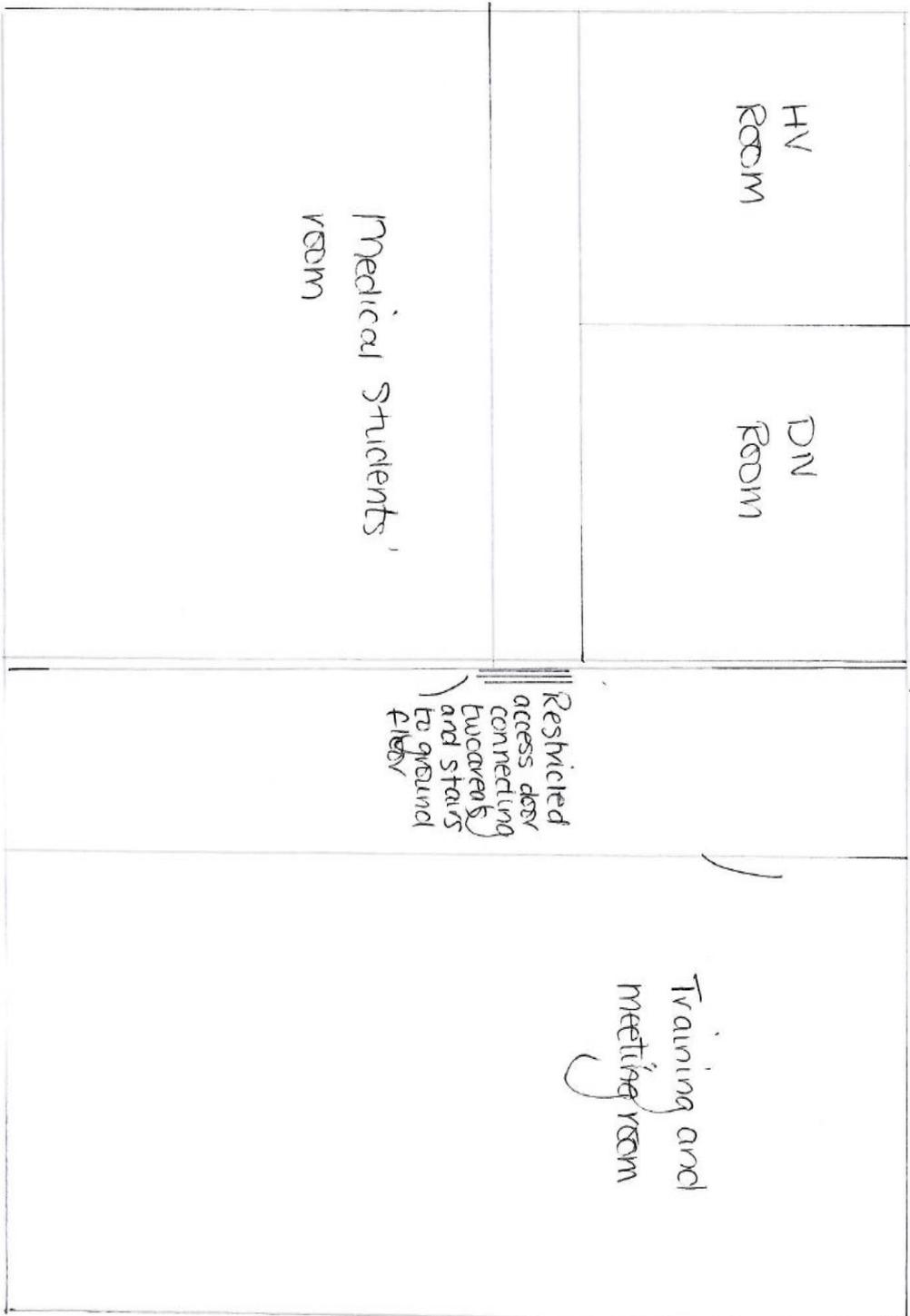
Plan of Practice Two (not to scale)



Plan of Practice Three (Ground floor: not to scale)



Plan of Practice Three (first floor: not to scale)



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