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Original Citation

Thurgood, Graham (1992) Let's work together, let's learn together. *Journal of Advances in Health and Nursing*, 1 (4). pp. 51-77. ISSN 0960-9857

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*Journal of Advances in Health and Nursing
Care ISSN 0960-9857; Vo11:4; 51-77
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Let's work together, let's learn together

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Summary: The problems of providing health care are discussed in relation to multidisciplinary clinical teams. The difficulties of working in effective multidisciplinary teams are explored, as are the potential benefits for patients who are cared for by the health professionals in these teams.

The methods of education and training for health care professionals are discussed and the problems including practice shock are identified. Methods of minimising the effects of these problems are assessed.

A review of policy making for health care professionals' education and training is provided, with reference to its relationship with general and higher education.

Problems caused by a lack of policy making are discussed. Finally, the various health care professions are assessed relating to the issues of professional power and the process of professionalisation: The opportunities for shared learning are outlined and the views of professional bodies examined.

This is the first of two papers exploring multidisciplinary education for health care professionals. The second paper, to be published in the next issue, presents the results of a study into this subject.

The concept of multi disciplinary clinical teams (MDCTs) has existed for a number of years but following recent actual and future potential changes in the health service, the value of this concept may need to be reviewed.

Multidisciplinary
clinical teams

Professional power

Professionalisation

Changes in nurse education and in general education institutions suggest the education and training of health care professionals who may work in these MDCTs may also need reconsidering.

Let's work together

Problems of providing health care

"The rapid increase in scientific knowledge and technology in the health field in the past quarter of a century has resulted in the emergence of multiple health disciplines," (Snyder, 1981). Since this statement, change within health care has continued to occur and the demands upon the health care system of the Auto Immune Deficiency Syndrome (AIDS) is just one example. Sills (1988) stated that "professions have many virtues but they also have vices, including isolationism, preciousness, tunnel vision and the propensity for reactionary defensiveness."

Bower in 1972 suggested "fragmentation is a major problem in the health care delivery system," (Snyder, 1981).

One patient may require a number of specialists to help them meet their health needs. Unless these specialists are organised "several disciplines may concentrate on one patient but do not co-ordinate their treatment plan, which may create additional problems," (Snyder, 1981).

The problems of lack of co-ordination of teams is also illustrated by Von Schilling (1982), who stated:

Yet when these professions are utilised one by one, each approaching the patient unilaterally, enormous problems of fragmentation, duplication and other inequities are created for the client.

Runciman identifies the problems of "separate records, and of access to them, individual team members worrying in isolation about the same care-related problems and overlap and duplication effort," (Runciman, 1989).

Rivett (1987) gave an example where a patient was asked his name, age, address and other basic data five times during an admission procedure, by different disciplines. This indicates inefficient use of time, human resources and finance.

Snyder (1981) concludes "the health care system contains few mechanisms for unifying the endeavours of the many health disciplines."

Unless a team approach is implemented, it seems that modern complex health care cannot be delivered efficiently, economically or effectively. This has obvious implications for quality assurance and standards of care.

Multidisciplinary clinical teams

For a number of years, the concepts of multidisciplinary clinical teams (MDCTs) of health care professionals in both institutional and non-institutional care settings have been developed, and discussions relating to them published (Scott-Wright, 1982; Barber and Kratz, 1980; Batchelor and McFarlane, 1980; Milne, 1980; Von Schilling, 1982; Wilkie, 1982; Hutt, 1986; Jones, 1986; Beatty, 1967; Bassett, 1989).

The majority of these published works relate to multidisciplinary teams in community care. The primary health care team has been a focus of attention but hospital based multidisciplinary teams have also been discussed.

The interest in multidisciplinary teams of health care professionals has increased during the past twenty years for a number of reasons. One of the main reasons has been a recognition that "no one health service discipline can provide all the knowledge or resources required," (Scott-Wright, 1976).

No one professional has the knowledge, skills or attitudes to be able to provide the total care and treatment for any individual patient's needs. This is particularly relevant with the increasing elderly population which brings all the associated problems of multi-pathology disease processes. The elderly have been identified as a group who can benefit from professionals educated together to work in multidisciplinary teams (Beynon *et al*, 1978; Hutt, 1980; Croen *et al*, 1984; Fielding P, 1987; Runciman, 1989).

In the OECD/CERI report 'Education for the Health Professions Policies for the 1980s', it is stated:

The quality of life for 80 year olds, for example, depends on the co-operation of housing, social services, health, education, transport, finance and communication among others (Regan and Schutze, 1983).

As a large proportion of the health service consumers are elderly, the importance of educating health care professionals together for multidisciplinary team working can be seen. The Kings Fund Project Paper on MDCTs defined

these teams as "a group of NHS and other workers who are contributing to a patient's (or client's) health or care." It also suggested that members of the MDCT bring along "their skills to bear on the treatment and care of an individual patient," (Batchelor and McFarlane, 1980).

Carpenter quotes Payne (1982) when defining what a team is:

A group of people working together, trying to plan their work so that each individual's activities take account of that of others and who attempt to use their togetherness to improve their work (Carpenter et al, 1986).

MDCTs can be formal or informal and are not popular with all professionals. Problems of status and leadership are just two of the difficulties associated with forming MDCTs.

Problems of MDCTs

If MDCTs are to be used effectively, the problems of these teams must be considered and their effects minimised or avoided. As stated previously, status and leadership are two problems associated with MDCTs. Status, power, prestige and control were all identified as problems of forming MDCTs (Leininger, 1971).

This was linked to the hierarchical pyramid team structure. Gomes developed this further with Peplau's pyramidal team structure (Gomes, 1985).

Carpenter *et al* (1986) identifies a taxonomy of teams and discusses complex teams. He cites Webb and Hobdell as

describing the problems of teams in relation to hierarchical organisation, both within and between professions.

Status and leadership continue to be problems which bring conflict to the team. This is explained by Clough (1981), "threats to professional status will naturally be resisted vigorously, and opportunities for increasing status seized and exploited." Each profession tries to "protect its own domain," (Harris *et al*, 1978). This was described as 'empire building' (Owen J, 1987).

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) indicates:

Co-operation and collaboration is not always easily achieved if individual members of the team have their own specific and separate objectives or one member of the team seeks to adopt a dominant role to the exclusion of the opinions, knowledge and skills of its other members (UKCC, 1989).

Often each profession has a different perception of, or attitudes towards each of the other team members (Croen *et al*, 1984; Beatty, 1987).

Leininger (1971) identified 'distorted role expectations' and 'role stereotypes' as major problems. She suggested a lack of knowledge of the contributions of other disciplines meant the talents/skills of some health disciplines are "grossly under utilised or over utilised."

In their research into the opinions of medical students about professional education, Rezler and Giannini (1981) concluded that in health care delivery there were:

limited referrals to allied health professionals by doctors either because:

- 1) *doctors were only partially aware of their skills*
- 2) *doctors do not value their own contributions*

This can be linked to the work of Croen *et al* (1984), related to the care of the elderly. They suggested:

Undervaluation of nurses' knowledge and expertise by medical staff is a major factor in their dissatisfaction and frustration, and inevitably leads to high turnover, burnout and dropping out of the system.

The lack of understanding of roles may therefore lead to "under-utilisation of skills, lack of job satisfaction and low standards of client care," (Bell, 1988).

Other problems associated with MDCTs include interprofessional jealousies or rivalry (Fielding P, 1987). Professional one-upmanship is a similar problem (Gomes, 1985). These professional barriers create further problems, particularly communication as stressed by Jones (1986). Areas of role overlap are identified as causing conflict which inhibits communication (Bell, 1988; Fielding K, 1989). Matthews suggests one major problem is the difference in ideologies between the disciplines (Pearson *et al*, 1984). Croen *et al* (1984) stated that "if we are to improve the quality of care provided to the elderly, existing differences in role perceptions and barriers to communication cannot be ignored."

It can be seen that MDCTs bring with them problems, some of which are similar to the problems of providing care without a team approach. Problems of teamwork can be avoided or reduced if the members are motivated and if they have the common goal of providing health care of the highest standard to the client/patient. They should be prepared to prevent professional barriers limiting communications and discuss demarcation areas of work. Often, tasks or skills which are not valued by the profession as important are relinquished/devolved to other professionals. This occurs between medical and nursing staff, creating an 'extended role of the nurse', where nurses perform skills/procedures traditionally performed by doctors, such as taking blood, administering intravenous drugs and suturing wounds.

The medical profession has usually taken the leadership role in MDCTs as most health service provision is based on a medical/curative model. However, it has been argued that the doctor may not be the most appropriate leader in the care of the mentally ill/handicapped and the elderly within the community. The 'key worker' concept is changing the automatic leadership role of the doctor. There is now some questioning of the doctor's leadership ability and right to leadership of MDCTs (Smith L, 1987).

This is supported by Clough (1981) who states:

Interdisciplinary collaboration, for example, may imply for nursing the continued dominance of the medical profession in spite of the fact that much of the work, particularly with handicapped children, would be of a social, educational and psychological nature.
Leadership

of such teams should not therefore necessarily come from the medical profession.

Let's learn together

Education and training of health care professionals

The education and training of health care professionals at both pre-registration/undergraduate and post-registration/postgraduate levels can be seen as having an influence on health care professionals' ideologies, attitudes and knowledge about multidisciplinary team work.

As long ago as 1971, it was claimed that:

Students in different health professions can complete a two to eight year educational programme without having learned much about the roles, educational preparation, practice expectations and skills of other health professions. Yet as graduates, they are expected to work together in a collaborative and co-operative manner in diverse health settings (Leininger, 1971).

She further stated that:

If students are all educated in isolation, a lack of knowledge of the different disciplines will lead to a lack of understanding and respect, interprofessional competition and a stereotyping of roles (Leininger, 1971).

Fragmentation

Lynch felt fragmentation in the health care system as being considered "one of the major problems facing health care professionals," (Beatty, 1987). Fragmentation was due to "rising isolationism in health professionals' educational programmes and students being prepared to function in their own disciplines for their own profession's purpose," (Beatty, 1987).

Practice shock

It was noted that upon qualification the realities of practice meant "group, team or integrated methods of health care" had to be used, which the professional had no experience or knowledge of (Beatty, 1987). Connerly described this experience in 1977 as 'practice shock', having to work with other professionals on the same patient (Beatty, 1987).

Traditionally, each profession educates its own members at independent schools and may not be aware of the practice shock suffered by students. Harris *et al* suggested that the realities of practice have stimulated efforts "to expose students in schools of health sciences to the knowledge and practice of others." They state pressure for educating students in multidisciplinary settings "tended to emanate from professionals in practice rather than those in academic settings," (Harris *et al*, 1978). This may be one reason why the development of multi disciplinary education has been slow as the educational policy makers see no need or urgency for this. The isolation of students during training in a single professional establishment was emphasised by Jones (1986)

when he identified they "spend almost all the crucial years of acclimatisation alone with professional peers." "It is hardly surprising that professionals find it difficult to come to terms with sharing care when they finally emerge into practice," he concluded.

How to overcome these problems

In order to overcome this isolation of students, practice shock and lack of multi disciplinary team work preparation, there is a need to review and develop health care professionals' education and training courses. This can be started by ensuring:

Students have opportunities to establish dialogue with persons from other disciplines and thus have a greater opportunity to learn where they fit in the larger health care delivery picture (Leininger, 1971).

Contact between students of different disciplines is seen to be important in both basic and post-basic education, although the foundations of co-operation between professionals can be laid more effectively during the early years of training. Appreciation of professionals' 'differences' "can be best facilitated when health practitioners are students," (Turnbull, 1981). This is supported by suggesting it is "important to provide opportunities at undergraduate level when minds and attitudes are likely to be most flexible," (Scott-Wright,1976).

In the Briggs Report it was stated that:

In the interests of continuity of care in an integrated NHS, it is essential that all caring professions should thoroughly understand each other's roles and work co-operatively in teams (DHSS, 1972).

In the Council for Professions Supplementary to Medicine (CPSM) report (1970), it was identified that the roles of professions are changing and this requires the need for frequent reviews of the patterns of training. It concluded that training changes as patterns of patient care change.

Nearly thirty years ago, it was identified that "better opportunities for social intercourse between students of various disciplines would lead to better team work when the students became qualified," (Crichton and Crawford, 1963). Crichton and Crawford (1963) also noted that "since co-operative behaviour patterns are established during the training years, we believe that there should be considerable rationalisation of effort in providing training."

Pickett (1977) adds that:

As the degree of specialisation or uniqueness of each profession increases, there will be an increasing need to explore the interface between professions and to pay attention to the development of skills and co-operation, interaction, communication and team work in the members of all the helping professions and to do that as part of the students' basic training.

There is therefore plenty of support for the introduction of multi disciplinary education or shared learning opportunities for professions. The need to introduce health professional students to different disciplines during their initial education

programmes is stressed. Eventually, this may improve the practice of professionals in teams.

Gomes suggested "health workers should have some form of common core training," and that students should get together "instead of working in isolation, and plan a common core which would be an integral part of all health students' training," (Fielding P, 1987). This was to overcome:

Interprofessional competition, make better use of human and natural resources and allow the health professionals to focus all their attention on the patient rather than spend time wastefully on professional one-upmanship (Fielding P, 1987).

Policies for education and training of health professionals In 1987, Newman suggested there are "still few multidisciplinary health care programmes," despite the World Health Organisation recommending in 1981 that "health care workers should have learning experiences together," and that there is no national commitment to these recommendations (Fielding P, 1987).

The OECD/CERI Report in 1983 identified that "the systems for educating health professionals have been slow to move, and the reason seems to lie in the structure of educational systems," (Regan and Schutze, 1983). Regan and Schutze (1983) report that policies regarding the basic education of health professionals "are not as developed as are health care policies." During the 1960s and 1970s, they state "the dominant unwritten policy for education of health professionals was a simple one: more is better." All member

countries had aimed their health manpower planning policies "toward improving accessibility and quality of health care by means of producing more health professionals."

Problems caused by lack of policy making

Two main problems relating to a lack of policy making for the education of health professionals were identified. First, it was reported that:

Most Ministries of Education have no coherent set of policies regarding education of the health professionals, nor do they possess organised management systems for carrying out such policies (Regan and Schutze, 1983).

However, since 1983 more health care professional education has moved into the higher education system, and with the recent introduction of independence for polytechnics, there may be more effort put into policy making in the future. Regan and Schutze (1983) point out that this lack of policy planning is a major problem when you consider "the education of health professionals consumes one quarter to one third of national expenditures on post-secondary education." The second problem they identified is that "few Ministries of Education have mechanisms of co-operation with the Ministries of Health at central, regional or local levels." However, they do identify a number of countries with "comprehensive and formal policies regarding education of the health professions: Canada, Greece, Nordic countries, Spain, Turkey and USA." The United Kingdom was not identified on this list.

In her overview of developments in nurse education in Australia, Parkes (1984) questioned why nurse education was not financed from educational funds and described how Australia followed the USA in believing preparation of nursing "belongs completely within the system of higher education." She further reports that in 1976 the National Nursing Organisations adopted as their official policy, a statement for the future direction of Nurse Education in Australia. The major aim being to:

Transfer all basic nursing programmes, which prepare professional nurses, to multidisciplinary educational institutions within the system of higher education, and provide both breadth of education and comprehensive nurse preparation.

She states that prior to this there was no specific government policy dealing with nurse education, nor had any policies on nurse education been developed by the nursing organisations. The policy goal was to be achieved by 1987 (Gibbs and Rush, 1987).

In the UK, nursing education is also changing with 'links' with the higher education system being made. Also in 1989 a strategy for nursing was published (DHSS, 1989).

This development comes after comments from various sources such as Owen GM (1988), who states that the UK seems to be:

About 20-30 years behind other countries like USA, Canada and Australia, in developing health professionals' education and providing opportunities for sharing learning.

In many countries, changes in policies for education of health professions are occurring incrementally. It is noticeable that there is a lack of co-ordination between the health professions' education systems and higher education systems in the UK.

Professions

Professionalisation and professional power

The changes in Australia described by Parkes are similar to the changes presently occurring in the UK, such as the UKCC's Project 2000 proposals for nurse education (UKCC, 1986).

Parkes does not give specific reasons for the policies Australia followed but Ashkuri (1988) suggested one reason was the need to increase standards of care, and another was to increase the status of the nursing profession by "educating students in a similar manner to most other professionals in the health service." It was suggested that the Australian government was committed to "rationalisation of health care and that training nurses in hospitals was no longer economically viable."

The Strategy for Nursing Report identifies as its twenty ninth target for education that "the number and organisation of schools of nursing and midwifery should be rationalised and linked with establishments of further and higher education," (DHSS, 1989). This seems to show a close relationship with the Australian policy. The English National Board (ENB) recommends formation of collaborative links between

approved training institutions within the NHS and centres of higher education (ENB, 1989).

However, it must be recognised that the nursing profession:

Cannot reorganise its own education system without taking account of other trends in society - and so many variables are interrelated that planning becomes an extremely complex and risky exercise (Owen GM, 1988).

Morle (1989) identifies that reports from the CPSM, ENB, UKCC and Department of Education and Science (DES) all emphasise the advantages of links between schools of nursing and higher education. She stated:

Increasingly, our paramedical colleagues are making strenuous efforts towards increasing graduate strength. How long will it be before these professional groups opt for all graduate status? If this should occur ahead of such a move in nursing we may all find ourselves the academic poor relations in the caring team.

Her comments show the changes in health care professional education are related to moving into higher education to improve professional and academic status.

Chiarella (1988) identifies the "enormity of the change which is occurring in nursing - from a non-academic occupation to an academic profession."

This must apply to other professions as well. One example suggests pre-registration degrees are the first step along the continuum of professionalisation with degree status for physiotherapy. This compares with speech therapists and

dieticians who all attained graduate status by changing the source of funding from the Department of Health to the Department of Education and Science (Palastanga, 1989).

There has been a slow move of health care professional education away from unilateral schools to colleges, polytechnics and universities during the last ten years or more (Myles, 1989). This trend towards professional status, links with higher education and degree status courses has been seen in the USA and Australia prior to its development in the UK.

Smith and Todd (1978) comment that:

An integral part of any occupation's struggle for autonomy and recognition as a profession is the development of long periods of training, leading to more exacting entry qualifications. This trend can be observed in many of the paramedical occupations and not least in nursing.

In 1963, the training of health professionals was questioned:

Are the professions being realistic about the work done and skills required to do it? Or is it important for comparative status to ensure that training is protracted and more thorough than is really necessary? (Crichton and Crawford, 1963).

This is illustrated in relation to medicine, "doctors often jealously guard their area of practice and perform many tasks which fall more appropriately within the scope of other professions," (Bowling, 1983).

A strategy of professionalisation was discussed by Salvage (1988) who saw professional status as a natural occupational goal. She stated this may be an "undesirable goal, tainted with the elitism and other short-comings usually laid at the door of medicine."

Cross questioned if Project 2000 is "an attempt to professionalise nursing and further the discrimination against lower social classes and minority groups," (Salvage, 1988). Morle (1989) further questions if Project 2000 "seems to have gone a long way to develop the academic status of nursing, but perhaps it hasn't quite gone far enough."

The Merrison report 'Royal Commission on the NHS' stated that the:

Power of professional bodies to limit entry to the profession and develop longer, more thorough training, may meet the registration needs of the profession but does it meet the NHS needs? (HMSO, 1979).

One way to claim the exclusive rights to professional practice is to "claim a special expertise, and to reinforce this claim through rapid changes in education and training in order to establish legitimate profession qualifications," (Clough, 1981).

The education of the medical profession, although seen as superior to other professions, is longer but "still fairly narrowly directed at disease processes and treatments," (Batchelor and McFarlane, 1980). They suggested "longer education should not be equated with better." The quest for professional status by some professions is therefore linked to professional competition and professional power and this is

directly linked to working in MDCTs and the problems that this brings.

A useful summary is given by Furnham *et al* (1981):

This century has seen the rise of a number of largely hospital based sub or para professions which have all attempted to establish control over a particular category or aspect of illness and its treatment and over a particular technical apparatus or process. Each group has attempted to achieve the status of a profession in order to establish their autonomy and self regulatory abilities.

However, the move of health professionals' education towards higher education creates an ideal opportunity for health care educators to plan and implement multidisciplinary courses and encourage shared learning between students and this may help to overcome these problems of professional status and power.

Shared learning

Although the climate and opportunities for health professionals to share learning may have improved, and may become more favourable in the next decade, the problems of professional status and power remain obstacles to successful multidisciplinary education courses. Gomes (1985) suggested that "not all groups are interested in reducing hierarchies." She identified that doctors would be "unwilling to be pulled off their pedestal."

Scott-Wright (1976) concluded "the most privileged in the health care team has not only the most to give but the most

to lose in any such experience." She continued "doctors will need greater persuasion than any of the other members to cooperate and share their rich educational heritage."

A study in 1972 looked at the influence system of interdisciplinary education between nurses, doctors and pharmacists. It looked at the student's value of expected results (benefits) against the costs incurred and found that lower groups were eager for contact with high power groups (doctors). High prestige groups wished to have few contacts with persons of other disciplines. The conclusions were that doctors were less interested in interdisciplinary education than lower power disciplines (Yeaworth and Mims, 1973). This would seem to be reflected in the vast amount of change that has occurred within nursing and paramedical education recently and the relative static position of medical education. The main changes within the medical profession in this country appear to be in primary health care, where general practitioner trainees (GPs) experience shared learning with other community staff.

The successful implementation of multidisciplinary education can only be by "the inclusion of medical personnel or students, however difficult it may be to achieve," (Scott-Wright, 1976).

Professional bodies

It is interesting how the health care professional bodies respond to the concept of multidisciplinary education and practice. In relation to medicine, Hippocrates stressed the importance of the physician's recognition of the

contributions of others to the patient's well being (Cox, 1982).

Clause Five of the UKCC's Code of Conduct states:

Each registered Nurse, Midwife and Health Visitor, in the exercise of professional accountability shall work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team (UKCC, 1989).

In its advisory Document on Exercising Accountability, it stresses the need for "multi professional and multiagency activity," which is based on "mutual understanding, trust, respect and co-operation." It further states that:

The UKCC and the General Medical Council (GMC) agree that there is a range of issues which calls for co-operation between the professionals at both national and local level and wish to encourage this co-operation (UKCC, 1989).

For nurses to be registered, they must be able to demonstrate several competencies stated in the ENB Rule 18. Rule 18(h) states that the nurse should be able to "work in a team with other nurses, and with medical and paramedical staff and social workers," (ENB, 1983). This should ensure the teamwork aspect is included in the curriculum for nurse education.

The ENB has also ensured that shared learning should be encouraged in the new Project 2000 courses. In their guidelines they state:

The information will enable curriculum planners to include shared learning opportunities for students undertaking the common foundation and branch programmes. In certain circumstances this sharing can be inter-professional where it can be shown that this will ultimately benefit patient care and student education (ENB,1989).

One of the learning outcomes of Project 2000 is "the ability to function effectively in a team and participate in a multiprofessional approach," (ENB, 1989).

The Chartered Society of Physiotherapists' (CSP) 'Curriculum of Study' states one of its aims and objectives is to "teach and advise patients, relatives, medical practitioners and other members of the health care team on the physiotherapeutic management," (CSP,1984). Under the section 'Organisation and Administration of Health Care', the student should be able to "describe the structures for health care, primary health teams, out and *in* patient care," and "describe the working relationships of the health *authority* physiotherapy service with other key workers." Also, under clinical education the student should be able to demonstrate "an ability to liaise with disciplines involved in health care," (CSP, 1984).

In the British Association of Occupational Therapists' (BAOT) recruitment leaflet, it states occupational therapists "work closely with other professionals such as doctors, nurses, psychologists, social workers and other therapists," (BAOT, 1988).

It is clear that most of the health care professionals are aware of the importance of working together in teams, but do not directly relate to the educational process as one means of assisting them to achieve this.

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