Interprofessional working.

Abstract.

This paper considers interprofessional working within one diagnostic imaging department.

The literature is still divided about the long-term impact of interprofessional learning in pre-registration health and social care education, and its impact on the quality of care provided. When reading the literature about interprofessional working the main topics considered by other authors are team working, communication between professionals, stereotyping and tribalism.

The results presented are from an ethnographic study in one department with participant observation and semi-structured interviews.

The three main aspects discussed in this paper are; tribalism and culture within the diagnostic radiography profession, communication between different professional groups, and a lack of understanding of the roles of other professional groups.

It was evident from the results of this study that tribalism and culture, and a lack of understanding were significant barriers to interprofessional working.

It was felt by the authors that pre-registration and post-registration interprofessional education could be significant in changing the culture of the NHS in the future as more professionals learn from and about one another.

Introduction.

This paper looks at interprofessional working in practice within a diagnostic imaging department. The authors were particularly interested to see if the advent of interprofessional learning (IPL) in pre-registration health and social care education has had an impact on the way that professionals work with one another.

The value of collaboration between health, social care and employment was recognised in The Beveridge Report in 1942 which laid the foundation for the modern welfare state in the UK. Despite this report, however, the National Health Act 1946 and the National Assistance Act 1948 created a system whereby health and social care were separated rather than being brought together, a situation which remained until the end of the 1970's. Through the 1960's, 1970's and the 1980's there was a flurry of activity related to interprofessional working by the government. It was not, however, until the mid 1990's that this flurry of activity became a rush with almost every Department of Health publication calling for health and social care professionals to work collaboratively[1].

In the latter part of the last century and the earlier part of this century a number of White papers were published[2,3,4,5,6] which have shaped the way in which current health and social care professionals are educated at both undergraduates and post registration levels. Regulatory bodies[7,8,9] are now supporting pre registration health and social care programmes to include interprofessional learning.

The long term impact of IPL on interprofessional working in practice is notoriously difficult to quantify[10,11]. IPL within pre-registration health and social care education has been in place within the universities since 2000[12]. However, it is still not clear from the literature if IPL has had a positive effect on interprofessional communication, collaborative working and the quality of care provided to service users. Reeves et al.[13] in their systematic literature review concluded that it was not possible to draw generalizable inferences about the key elements of IPL and its effectiveness. It is

acknowledged that IPL should have a positive effect on practice and the way in which health and social care professionals work together. Barr and Low[14] suggest that IPL should improve patient safety by improving communication and collaboration between professionals. There is general agreement between educators and practitioners that interprofessional collaboration and working is important and that the care of the service user should be paramount. In caring for service users with complex needs, a team approach is important so that professionals can respond collaboratively to these complex problems which may need the experience of more than one profession[14].

IPL should therefore both improve interprofessional collaboration and the quality of care[15]. The quality of care to service users within the NHS has always been an important issue. Lord Darzi's report[16] highlighted this and since the publication of the Francis report[17], the quality of care has become even more of a key issue.

In this paper we discuss the interprofessional working observed during an ethnographic study of the culture within a diagnostic imaging department. This paper is drawn from three of the themes identified from the data which are being discussed in relation to other studies and relevant interprofessional literature.

Literature review.

Since 2000, there has been much written about IPL within health and social care education and interprofessional working in health and social care practice[18,19,20,21].

The main subject areas discussed in the literature are team working, communication between professionals, stereotyping and tribalism. These subjects are also very closely linked together.

A team is a group that has a sense of a common goal or task, the pursuit of which requires collaboration and the coordination of its members; the team have regular interactions with each other[22]. In the case of health and social care professionals, this common goal will be the care of the service user, and the team will be service user focussed. Teams are successful when all of the members work together and there is equality and balance within the team. This appears to be more challenging when team members are from different professional backgrounds. However, team members need to be flexible and adaptable, allowing them to work across professional boundaries.

Shaw et al.[23] in their study of primary health care teams found that the teams that were limited in their effectiveness had the absence of a common goal, there was inadequate communication between the team members and there were hierarchical structures. In these teams there was a lack of understanding of one another's roles, and there was medical dominance and conflict. Team members said that it was difficult for the team to develop and for participants to feel involved as team players[23]. However, they also found some effective teams in their study where the professionals involved were able to work as a team and develop good quality, patient focussed care. "Team members have different skills and expertise and to function effectively communication is vital in achieving positive team working"[23 p400].

Xyrichis and Ream[18] also support the notion of effective communication and valuing team member's knowledge and expertise in effective interprofessional team working.

Within health and social care, there are teams where there is only one representative from each profession, for example in community mental health teams where there might be one social worker, and one mental health nurse, or in the operating theatre where there might be one operating department practitioner and one radiographer. This can lead to professional isolation for the members of staff involved and problems with professional identity. Rose[24] carried out a study of interprofessional teams working in children's services, in these teams there were one or two representatives from each professional group. She found that the participants liked to remain allied to their own specialism and often felt like outsiders in a different professional culture. She concluded that professional identity was important to her participants and a lack of professional identity led to the feeling of insecurity. Therefore, she felt that successful collaboration in an interprofessional team may require some degree of professional sacrifice[24].

Molyneux[25] in her paper about successful interprofessional teams explored how and why co-operative and collaborative working relationships developed in an interprofessional health team in the north east of England. The team described, worked together across a geographical area, and across professional and organisational boundaries. The team worked together successfully because there was equality and balance within the team, and no team member sought to dominate the team. The team members had trust and confidence in one another and problem solving was open and honest. In this successful interprofessional team the staff

members were flexible and adaptable and were able to work across professional boundaries.

Laidler[26] calls this 'professional adulthood'. She says that professionals need to be sufficiently confident in their own role and professional identity to feel safe to share and to defer professional autonomy to another professional and to work together. Otherwise, interprofessional jealousy and conflicts arise.

Unfortunately in any environment where staff members come from different professional backgrounds there will be tribalism. Different professions each have their own occupational culture which differs from other groups and leads to distinct tribal groups[27]. In-group and out-group behaviour and constructions of 'the other' are well known in social research[21,28,29]. There is an understanding that groups tend to classify themselves as 'us' and all other groups as 'them'. 'They' are seen as 'the other', and this 'otherness' implies both differences and a different status. Most often the 'other' is viewed as inferior or of less value than 'us', and is subject to stereotyping and prejudice[30]. This is seen in the armed forces[31], and other large organisations as well as health and social care.

Mandy et al.[27] saw this in their study of professional stereotyping in interprofessional education, "individuals who identify strongly and positively with their own professional 'in group' will rank the 'out group' or other professional group more negaitvely" [27 p163]. Hean et al.[32] also found this in their work on stereotyping.

Lingard et al.[33] carried out a study of professionals working in the operating theatre. This work focussed particularly on the use of talk or discourse amongst professionals and how it is used to facilitate relationships and our role within a team. All professionals have an identity and a view of other professionals. Novices to a profession construct a sense of their profession via legitimate peripheral participation[34] and via discourse. Through this they learn their profession's duties, boundaries, values and aspirations. At the same time, they also construct a view of the 'other's, i.e. those from different professional groups. It is often during moments of tension and the exchanges that follow, that judgements about 'others' are formed.

The language and terminology used by other professionals can also be a barrier to interprofessional team working. In an interprofessional group it is important that all members of the group understand the language and terminology being used[35].

It seems that many professionals do not really have a full awareness of the roles of other professionals, and this can lead to prejudice and misunderstanding. Eggerston[36] writes about doctors and nurses who had worked together for many years in an intensive care unit (ICU) not really knowing what each other did and what each profession's daily activities and responsibilities were. She goes on to say that "mutual lack of education is one of the reasons for on-the-job-tension" [36 p28]. She suggests that all members of the interprofessional team need to know each other's roles and responsibilities and treat each other with respect.

So it can be seen from the literature[1,18,37] that interprofessional working requires good teamwork, communication and understanding and that health and social care

professionals need to have a good understanding of one another's roles and expertise in order to work together for the good of the service user.

Methodology.

A qualitative approach was used and ethnography was the chosen methodology. The workplace culture of the diagnostic imaging department was studied in order to gain an insight into the profession of diagnostic radiography.

Ethical approval was granted for this study from the local research ethics committee and the research and development committee at the Trust. The study was undertaken over a six month period and commenced with a four month period of overt participant observation carried out by one participant observer. This was followed by semi-structured interviews with ten members of staff from the diagnostic imaging department to investigate the issues uncovered in more depth. The department employed 25 full-time and 27 part-time radiographers, making a total of 44.69 whole-time equivalents at the time of the research. Only two members of staff opted out from being observed. Information about the staff members who were interviewed can be seen in Table 1.

The semi-structured interviews followed an interview schedule which was formulated to follow up on issues uncovered in the observation. Interprofessional working was a topic that was discussed in response to three of the questions;

- Can you describe the working environment in the diagnostic imaging department?
- How do you think diagnostic radiographers communicate with their colleagues?

- Do you think there is a radiography culture?

The data were analysed using thematic analysis. The data were contextualised, issues and events were reviewed in more detail. Patterns of behaviour were found and themes emerged from the data. These themes were categorised and coded. One of the main themes was interprofessional relationships, which looked at the relationships that diagnostic radiographers have with the other professional groups in the hospital. This was just one of the themes from the study and this is the focus of this paper.

Results.

There are a number of aspects within this theme which will each be discussed in this paper. These are:

- Tribalism and culture

- Communication

- Lack of understanding

Relevant data from the ethnographic study and other pertinent literature are presented along with a discussion of the implications of the findings.

Discussion.

Tribalism and culture.

It appeared from the study that radiographers worked together well as a team and the profession specific team was efficient. However, when it came to working alongside other professional groups there appeared to be territorial boundaries and

different professions appeared to 'guard' their territory (their own department). This was seen within the imaging department, and was aimed at 'outsiders' but it was also seen when diagnostic radiographers visited other departments within the hospital. This is an illustration of an 'in' group being territorial with an 'out' group[28].

The imaging department appeared to be a closed community, where outsiders and visitors did not feel welcome. One of the radiographers expressed this in her interview:

> "I think sometimes it can be quite intimidating to come into a group of radiographers, but when you do have to work so closely together you do start to shut other people out and particularly for doctors that are coming in… Junior doctors that come round with a form and are there thinking 'Oh my goodness, and I gonna be able to get this X-ray', they appear at the entrance to the viewing area and they look like they don't wanna be there! Radiographers will just let them stand there, so it can be quite intimidating for them."
>
> *Interview with radiographer.*

This, however is not the whole picture. During the period of observation there were occasions where radiographers described similar incidents when they were 'visiting' other departments, for example wards or theatres. On one occasion this was recorded in the observation notes:

> "The radiographers discuss how they do not always feel part of the team in theatre. They feel as if they are visitors and not all of the team make them feel welcome. The radiographers talk about the theatre staff knowing one another and calling each other by name, but referring to them as 'the radiographer'."
>
> *Observation 29/8/08, staff room.*

Radiographers also experienced this when working in Accident and Emergency (A&E). The A&E X-ray room was relatively new in this hospital and so radiographers had only been based in A&E for the past year. Consequently, they did not really feel part of the A&E team and spoke about this feeling of isolation.

"We used to be very isolated and not mix with A&E very much, and even though we have a room in A&E now, it is still difficult."

Interview with radiographer.

So it can be seen from these examples that each professional group were protecting their territory from 'others' who were not part of their group.

Wolf[38] describes this 'tribalism' in her seminal ethnography of the workplace culture on a hospital ward. She found that the nurses on this ward behaved as if it was their nursing team against the rest of the hospital, they acted like a separate team who were fighting against other wards and departments. The nurses on the ward that she studied supported their colleagues and behaved like a closed community. A workplace culture can promote this behaviour, where a group can behave in a very exclusive manner. This exclusive behaviour helps to define the cultural group, and makes group members feel part of the team, but excludes outsiders.

Every workplace develops its own culture[39] and this workplace culture can become a barrier to others. Rose[24] found this with some of the professionals she studied who felt that they had lost their professional identity because they were working in an interprofessional team in a 'different' environment.

Members of the group can exclude others through their behaviour, through the use of language[35], and by exhibiting shared beliefs and values[40,41]. Tribalism and professional culture can become barriers to working with other professional groups as they exclude others and create rivalry and hostility. Stereotypes and prejudice can result which leads to lack of co-operation and collaboration[32,33].

Communication.

Diagnostic radiographers work alongside and liaise with many different professionals within the hospital. Radiographers are key professionals in many patient pathways and as such they need to communicate with other professional groups.

During this study, several examples of interprofessional communication were observed. For example, with nursing staff from the ward.

> "When in-patients come down to the department, radiographers co-operate with the escort nurses. Radiographers are often on the telephone liaising with ward staff about imaging requests or speaking to referring clinicians."
> *Observation 11/8/08.*

This communication is important in understanding the needs of the patients and the radiographers gaining an understanding of the patient's capabilities. For example, if the patient can travel to the imaging department in a wheelchair then that means they can stand up, but if they are travelling by bed they are probably less mobile and this can have an impact on the radiographic examination.

When a nurse accompanied a patient to the imaging department, then the nurse and the radiographers worked together to carry out the examination. Communication between the professional groups was important in order to meet the needs of the patient. However, the diagnostic radiographer always took the lead in this situation as this was their department.

Communication also occurred in the A&E X-ray room with the A&E staff.

> "A radiographer and referrer discuss the imaging request together in order to establish the reason for the imaging request."
> *Observation 14/8/08.*

In this case it is the radiographer's responsibility to justify an imaging request, and so this interprofessional communication was important to clarify the best path for the patient and to ensure that both professionals were looking out for the patient's needs. There were other occasions where radiographers conversed with referring clinicians.

> "A doctor comes into the department to speak to a radiographer about an X-ray request."
>
> *Observation 29/8/08.*

All of these are positive examples of interprofessional working and communication, where radiographers were discussing their work with other professionals to ensure a good quality of care for the patient. In these cases the radiographers and other health care professionals had a common goal, that of the patient's welfare and so they were able to work together to achieve this goal.

Interprofessional working and patient care is enhanced through effective communication between professional groups[23,42,43].

Lack of understanding.

A lack of understanding of other professional's roles can be a barrier to interprofessional working. During the study, there were a number of occasions both during the interviews and observation where the radiographers talked about lack of understanding between professional groups. The radiographers spoke about how professionals do not always understand one another's roles and jobs.

> "The radiographers discuss how some surgeons do not seem to understand the role of the radiographer in the operating theatre and have unrealistic expectations."
>
> *Observation 11/8/08.*

This was discussed on several occasions and misunderstandings seemed to be a common occurrence in the operating theatre.

> "The radiographers talk about an orthopaedic surgeon who did not really understand what the radiographer could do with the c-arm in theatre, and could not understand why the radiographer wanted to know the pregnancy status of the patient."
>
> *Observation 12/8/08.*

One of the radiographers felt that all professional groups were to blame for this. this was recorded in the observation notes.

> "One of the radiographers talked to me about how communication is important in understanding how other professionals work. She believed that everyone should take responsibility for this and be prepared to explain our professional role to others. Her feeling was that we cannot just criticise others, we need to take some of the blame ourselves."
>
> *Observation 14/8/08.*

One of the radiographers explained in her interview that she was not always aware of the roles of other professionals.

> "You get the occasional doctor or nurse that can be quite rude because they don't know what we do, but then they could say the same about me because I've not really got a clue about what they do either!"
>
> *Interview with radiographer.*

It appears that there is a general lack of understanding of the roles of others. In order for professionals to work together to enhance the quality of the care to the service user, they need to know what each profession does and how they can each contribute to the care of the service user. The NHS core values underpin this in terms of working together for patients and a commitment to quality of care.

Lack of understanding is cited by other authors[44, 45]. Eggerston[36] discusses this in relation to doctors and nurses working together on ICU for many years. Atwal and Caldwell[46] make it clear that working in an interprofessional team involves "understanding not only one's own role but also the role of other professionals" [p359].

Each profession's contribution to the patient pathway is important. It is relatively easy for a radiographer, nurse, doctor, physiotherapist or other professional to work in isolation and do their job without giving much thought to the bigger picture – the rest of the hospital and the service that patients receive.

The implications of these findings are that if professionals working in large organisations do not work together or have an understanding of the roles of others, then the organisation will not operate effectively. Professionals need to have an understanding of how their work can affect others. This lack of communication between staff and departments was evident at Mid Staffordshire[17].

There are also implications for education providers. Interprofessional learning and education is key to pre-registration health and social care education, students should be enabled to learn from and about other professionals[15].

Conclusion.

There are three main aspects that have been discussed in this paper; tribalism and culture, communication and lack of understanding. All of these are important aspects of interprofessional working, with tribalism and culture and a lack of understanding being significant barriers and communication between professional groups being important[17,47,48,49].

It is notoriously difficult to change the culture of an organisation, particularly one as large as the NHS[50,51,52].

There needs to be a greater understanding of, appreciation of and respect for the different professional roles with health and social care. This will allow professionals to work together, to communicate with one another and to collaborate for the common good of the service user. This in turn will help to meet the demands of the service and enhance service delivery.

Professionals need to develop the 'professional adulthood' described by Laidler[26]. They need to become confident in their own role and professional identity so that they can feel safe to defer professional autonomy to others and be able to work with other professionals for the good of the service user and the interprofessional team. This 'professional adulthood' is the key to IPL.

Pre and post registration IPL and education is significant in changing the culture of the NHS with regard to interprofessional working. Both students and qualified staff need to learn from and about one another in order to improve the quality of care delivered to the service user[15].

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