JOURNAL OF INTERPROFESSIONAL CARE, VOL. 14, NO. 3, 2000

The impact of individual philosophies of teamwork on multi-professional practice and the implications for education

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Summary *An emphasis on multi-professional teamwork and the development of shared learning to support this process figures prominently in current policy documents is the United Kingdom, information dissemination from professional bodies and Trust statements (DoH, 1997,1998; Calman & Hine, 1995; SCOPME, 1997). The assumption behind these prescriptions is that working collaboratively enhances the outcomes to patients. However, working collaboratively may not be readily achieved. This research was funded by the English National Board for Nursing, Health Visiting and Midwifery (ENB) used a case study approach to explore the factors which inhibited or supported collaborative practice. Case studies of six teams working in a variety of specialisms were conducted. There were difficulties in developing collaborative practice identified at three levels of analysis: the organisation, the group and the individual. Whilst organisational and group dynamic constraints may well impinge on practice, this paper would argue that the different interpretations which various professionals have of team-working are of equal importance. Three philosophies of teamwork which emerged from the data will be described and discussed using examples of professional interactions from the case studies. Given the problems identified where the philosophies of individual team members were mismatched, the implications for education will be explored.*

Key words: *Multi-professional working, individual philosophies, impact on teamwork, impact for patients, implications for education.*

Introduction

Multi-professional 'teamwork' has become the preferred model of practice promoted for many areas of health care by policy makers, professional bodies, and Trust management (DoH, 1997, 1998; Calman & Hine, 1995; SCOPME, 1997). Based on an assumption of beneficial outcomes for patients, the requirement of professionals to communicate 'effectively', to understand each other's contribution to the care process and to be prepared to blur the boundaries of their roles has been proposed in much recent research as the most effective form of managing patient care (Ovretveit, 1990; McGrath, 1991; Pearson & Spencer, 1995; Freeman & Procter-Childs, 1998). The evidence presented in this paper is taken from an ENB funded project (Miller *et al.*, 1999) which explored clinical multi-professional 'team-

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 ISSN 1469-9567 online/00/030237–11

work' in order to identify the skills and knowledge required by students to work effectively in this context, and then looked at current educational provision in terms of appropriate preparation. The evidence from the clinical 'teams' showed that achieving patterns of professional interaction identified above would appear to be fraught with difficulties; the 'ideal' of effective team-working as defined in the prescriptive literature is apparently rarely realised.

It is evident that many organisational structures and processes militate against the development of this approach to working, and yet the attitudes and behaviours of those who make up these 'teams' also seem to pose an equally major barrier. The way in which *individual understanding* of teamwork affects multi-professional interactions is the main issue with which this paper will be dealing. As one might expect, the same understanding may not be held by all members of a multi-professional 'team'. This research found that where there was a lack of congruence in how various aspects of teamwork were interpreted, it had the potential to compromise communication, the development of role understanding and, as a result, the level of team learning. It could exacerbate underlying resentments, undermine professional esteem, and in some instances, created outright conflict.

Using evidence from six case studies we identified *three interpretations* of multi-professional working. They have been identified as 'individual philosophies' because whilst they were to a large extent bounded by profession, this was by no means always the case. First, this paper will define the philosophies. Second, it will describe how specific aspects of teamwork were interpreted differently and illustrate from the case studies how this affected multi-professional interactions. Finally the implications for education and training will be addressed in the context of multi-professional shared learning.

Methodological approach and method of data collection

Research questions

The research used a case study design in order to explore the issues around professional interaction which inhibited or supported team-working. We also explored the way in which organisational structures and processes impacted on team function.

Research design

Case study (Simons, 1980) is a qualitative approach which addresses a particular area for research by examining the context within which it is embedded. As identified by Rolfe (1998), this approach is particularly suited to health care research which seeks to explore the multi-faceted and multi-layered interactions which combine to provide patient care.

Case study selection

Little was known about the teams prior to the research. However, teams were chosen from a number of specialisms. They included those in acute and community care, and those which straddled both services. All teams included a wide range of professions. One team with a national reputation was chosen for its apparent total integration of professional input to care. Each team was studied for a period of three months in order to develop an in-depth understanding of context and team practices, and to be able to determine chains of events and their outcomes.

Data collection

Data collection in this research included extensive observation of the field (approximately 100 hours per case study), repeated interviews with several members of each profession in the team (145 across all case studies) preceded by asking participants to provide pictorial representations of the team, and document analysis. In the process of data collection, many team/patient related incidents were observed and recorded, and followed through to their outcome, asking both team members and patients for their interpretation of events.

Data analysis

Analysis utilised a grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1992), whereby text from documents, interview transcripts, and field-notes were subjected to constant comparison. Items and events related to the research question were then coded and categorised. The emerging issues from these were subsequently subsumed within specific themes.

The teams

The following section gives a brief description of each team.

Diabetes team

The team comprised: a consultant diabetologist, two diabetes specialist nurses, two dieticians, and two podiatrists. The function of the team was to provide assessment, monitoring and education for all people with diabetes, through various clinic sessions. These sessions were frequently multi-professional in nature. Meetings were held for all team members once a week.

Primary health care team (PHCT)

The 'team' comprised the practice staff which included four GPs, who employed a practice nurse, a practice manager, four reception staff, and a counsellor. Other professionals in the 'team' were employed by two local trusts. They included two health visitors (HVs), who had an office on site, and a midwife and two district nurses who had offices elsewhere but visited the practice on a regular basis. All professionals ran a variety of clinics in the practice setting, and, in various permutations, attended meetings held at irregular periods on site. The sessions held in this practice were generally mono-professional in nature.

Medical ward team

This 'team' operated within a large 26-bed medical ward designed to have a respiratory focus. Within the ward there was a separate four bedded high dependency unit (HDU). The ward operated with a large number of trained and untrained nursing staff (27) and admitted patients who had presenting problems other than acute respiratory. As a result, 10 consultants from different specialisms (and their more junior doctors), visited to see patients, in addition to three physiotherapy (PT) teams, three occupational therapy (OT) teams, a wide variety of specialist nurses, and other relevant professionals. Ward rounds occurred every day, with only general times for these rounds being acknowledged.

Neuro-rehabilitation unit team

This team catered for medically stable patients who had recently suffered brain damage from a variety of causes. Patients were given a tailored course of therapy within a highly structured, problem focused, goal oriented programme. Collaborative note-keeping had been developed by the team. The unit was headed by a non-medical director, medical cover being given by a local group of GPs. The staff comprised a large group of trained nurses and nursing assistants who operated a team nursing model, with five patients per team. Other professionals included groups of PTs, OTs, speech and language therapists (SLTs), a social worker (SW) and a clinical psychologist.

Child development assessment team (CDAT)

Most of this team operated within a purpose built centre in the grounds of a children's hospital. The centre and the hospital belonged to two different Trusts. The team comprised paediatric consultants, SLTs, physiotherapists, OTs, a playroom teacher, nursery nurses, psychologists and an HV. Of this group, the PTs were employed by the hospital trust, only visiting the centre as and when necessary. The function of the team was to provide assessment, therapy and monitoring sessions mainly for very young children with special needs. Several of these sessions were multi-professional in nature.

Community mental health team (CMHT)

Two such teams were included in this case study. They comprised community psychiatric nurses (CPNs), SWs, consultant psychiatrists and an OT who worked between the two teams. The team's function was to manage the local care of all people between the ages of 18 and 65 who had severe or enduring mental health problems, in liaison with various other mental health facilities. Other than one weekly multi-professional meeting related to case discussion, much of the teams' business was conducted on a mono-professional basis.

Individual philosophies of teamwork

The identification of the different philosophies emerged initially from observing patterns of behaviour within the teams in relation to specific aspects such as communication and awareness of role contribution. For example, in terms of communication: what was being said, how was it said and to whom? In terms of awareness of role contribution: what did team members do in certain situations; what were their expectations of others' roles; what happened at the boundaries of those roles? These observations then prompted interview questions related to specific incidents; for example, how did team members perceive communication which had occurred and what were their expectations of such communication within a team context; what did they see as their own and other's contribution at that point and what was the rationale behind those perceptions? From these initial findings, more general understandings of beliefs about team working were explored, such as inter-professional (i.e. between individuals of different professions) learning within the team.

Other research (Poulton & West, 1993; Onyett *et al.*, 1996) has identified the following elements as a prescription for 'effective multi-professional teamwork': *shared vision, good communication, role understanding*, and *role valuing*. However, it became evident in *this* research, that the perceptions which individual professionals had of working with others lent *different meanings* to these elements. Although, as suggested earlier, there were other factors which impacted on team-working, having *different* perceptions of teamwork was seen to

inhibit professionals from working together of the effectively. Individual philosophies of team-working seemed to shape perceptions of the *need* for shared vision, what *constituted* effective communication and role understanding, and how *role contribution was valued*. In relation to these, the different philosophies led to different expectations of *learning from other team members*. The following section describes the attributes of each of the three identified philosophies which we termed: *directive*, *integrative*, and *elective*.

Directive

The *directive* philosophy was most frequently held by members of the medical profession, and by some non-specialist nurses. First, it was based on an assumption of hierarchy where one person would take the lead by virtue of status and power, and thereby direct the actions of others. For the 'director', being a team player was an acknowledged attribute but as a 'team leader'. Second, this philosophy created assumptions about *levels* of communication since the 'team leader' would determine *what*, *when*, *and how information was communicated and to whom*. 'Lower status' professionals who held these beliefs often did not welcome this approach, but colluded since they found it hard to challenge the status quo. Third, the philosophy made assumptions about understanding others' roles in terms of *tasks*. Where roles were lower in the hierarchy, they were *valued for their service* to the powerful role rather than having an intrinsic value in terms of insights into patient care. Finally, this philosophy had the potential to determine the way in which *professionals learned from each other*, since learning from others was apparently defined by status, with those in positions of power believing that they could only learn from their peers or superiors.

Integrative

In the *integrative* philosophy, professionals held the following criteria as fundamental to team-working. First there was a commitment to two aspects of being a team member: the *practice of collaborative care and therapy*; and *attention to being a team player*. Second, there was a *recognition of different levels of role understanding*, and their importance in the *development of negotiated role boundaries*. Third, there was *equal value assigned to each professional's contribution* to both the patient's progress and to other professionals' development. Fourth, there was an acknowledgement of the complexity of communication, which incorporated a belief that it should include *wide discussion and negotiation* in order to develop a *team understanding* of the patient. Finally it was assumed that professionals would *learn both skills and knowledge from each other*. This philosophy was identified most frequently in the therapy and social work professions, and among some nurses. In our case studies, where professionals shared this philosophy of teamwork, it was observed that they developed joint working practices.

Elective

The *elective* philosophy was essentially a system of liaison. In our studies, it related to those professionals who preferred to operate autonomously and referred to other professionals as and when *they* perceived there was a need. It was synonymous with *insularity of practice* and thus inhibited the development of a shared understanding of patient care. Second, there was an *attention to role clarity and distinctness* which precluded the negotiation of role boundaries. Third, there was a belief that *brevity of communication*, in order only to inform others, was more appropriate than discursive interaction. Finally, there was an ascription to a hierarchical structure of professions in which *learning was valued from those of equal or higher status only*. These beliefs combined to create distancing behaviours such as general lack of participation

in 'team' activities, for example, withholding case notes, and reduced attendance at meetings. In our studies, this philosophy was held most often by those working in mental health services.

The meaning of team-work: sharing or not sharing philosophies

This section describes the way in which holding specific philosophies shaped the meanings ascribed to the various aspects of teamwork and how this impacted on behaviour where meanings conflicted or married. In particular this relates to the willingness to engage in inter-professional learning.

The examples that are included in the following sections are representative of the particular type of interaction being discussed. Many similar incidents and comments were identified during the course of the case studies in relation to where individual philosophies met.

Shared vision

In terms of holding a shared vision, all professionals in the case studies maintained that they had a goal towards which they were all working, i.e. providing the most comprehensive care for the patient, in which there was accurate diagnosis and referral and continuity. However, only those who held the *directive and integrative* philosophies necessarily related this to '*teamwork*' (i.e. that people had *shared* goals, achieved by working alongside or with others). Those who held the *elective* philosophy tended to view team-work as a threatening concept, with professionals unsure or even hostile to the idea of working in a more participative fashion. For them the *one-to-one relationship with the patient* was more important in their practice.

Professionals who ascribed to the *directive and integrative* philosophies may have felt that they shared a vision of 'team care'. However, what this meant in terms of their day to day interaction was very different, and in fact actually worked against achieving their identified goals. This is clearly demonstrated in the following section on communication.

Communication

The expectations of those who held a *directive* philosophy were that only communication which pertained to their own professional actions would be required from other professionals. This could be extremely limiting for others who wished to share knowledge and information about a patient which was outside those parameters. For example, in the PHCT several of the doctors operated from a '*need to know*' basis. This meant that other professionals were only informed of what the doctors felt needed to be disseminated, and what they required others to do. Brief messages were frequently relayed in other professionals' communication books. The health visitor 'attached' to the practice held beliefs about teamwork which included a sharing of ideas and opinions. On one occasion she received a message from a GP to regularly weigh a particular child without being given a reason, and without the suggestion of any prior meeting to discuss her own knowledge of the child. She commented that information about the context of the child's home environment and the child's past development would have provided the GP with a wider understanding of the family situation. It would also have enhanced team interaction through the inclusion and thus recognition of the HV's particular skills and knowledge, and might have changed the way in which the GP managed the child's care.

The way in which some doctors set the parameters for communication was highlighted in

the medical ward. Here some were seen to require nurses and other professionals to give information in support of the medical path of treatment and care only. Whereas this *could* be viewed as satisfactory in some aspects of patient management, other aspects, such as discharge planning, demanded other input. In the medical ward for example, consultants were seen to tell patients they were ready for discharge, as a medical decision only. Other professionals later had to revoke those decisions in the light of their own professional understanding of the patient's condition, for example their social situation, or psychological issues. Direct challenge was rarely seen. However, one male nurse (who had been in a managerial position in industry) frequently put the nursing perspective forward (or information related to other professional input) if he felt the decisions being made required it. He felt that all nurses should be prepared to challenge since it ensured that decisions were made on the most comprehensive basis. He was seen to encourage other nurses on the ward to address consultants in the way he did:

> And I think a lot of the time if they know that you are going to talk straight to them, they'll accept it. But if you're going to fumble around the bushes, or they know you've got a weak spot then that's it.

Where professionals held an *integrative* philosophy, it was seen as important that time was given to discussion and debate, both informally and within regular forums. All professionals in the team would be expected to contribute and all domains of patient care would be valued for their provision of a full picture of the patient's progress. Professionals spoke about how beneficial it was to gain these multiple insights as they had the potential to persuade team members to make changes to the path of action they were considering taking.

For example, in the neuro-rehabilitation team there were a number of regular meetings at which patient progress was discussed in-depth, based on the use of a joint scoring system. At one meeting, two therapists each gave a different score for a patient's problem-solving abilities. Because of the degree of discrepancy the head of the unit asked one of the therapists why she thought the score should be so low. She described how the patient had not been able to manoeuvre between his wheelchair and a plinth to do a 'low transfer' in a logical manner. She felt that he had a poor ability to think the manoeuvre through. The other therapist was surprised, as the man had performed very well in a formal paper assessment. The first therapist then reflected that it may only be in physical situations that the man had difficulty conceptualising appropriately. As a result of this discussion, the two therapists decided to book a joint session to examine more closely how different settings might affect the man's cognitive skills. The outcome was an identification of problems of generalisability in terms of the man's cognitive skills.

In terms of the *elective* philosophy, those who chose not to communicate comprehensively with others, not only failed to gain the wider picture of the patient, but also prevented others from having full access to *their* assessments, decisions and actions. An example which demonstrates this was where a newcomer joined the neuro-rehabilitation unit, where there was an almost total commitment to *integrative* teamwork. It was expected of all team members that they regularly attended meetings and gave account of their actions, however this professional did not attend any meetings on a regular basis. When he did attend it was perceived that his contribution was unhelpful, offering little or no advice on particular patients and being uninvolved in planning processes. Furthermore, although all other members of this team wrote in joint notes, this professional declined to participate in the system, keeping his own notes locked in his office. As a result of this reluctance on the newcomer's part to reveal the bases of his clinical decisions, and how he intended to proceed with a programme of care, resentment grew among other team members and doubts were fostered about the extent of the newcomer's knowledge and skills. Furthermore, patients in

the unit were left confused and, in some cases, distressed as to their future care, often receiving different messages from the newcomer and the remainder of the team.

Role understanding and valuing

In the context of role understanding and role valuing, both the *directive and integrative* philosophies of teamwork presumed an understanding of other professional roles within the team and of valuing those roles. However, for those who operated within a *directive* philosophy this meant that they understood other's roles more in terms of tasks. Where a professional had status and power this was translated as other professionals '*working for*' rather than '*with*' them. So for example, a statement made by one GP was:

> And so if part of that process involves the practice nurse taking blood, I wouldn't really feel a great bond and sense of gratitude, you know 'we couldn't have done it without that,' because actually she would only have been doing a job I could have done myself, I'm just delegating the boring bit to her.

By the same token, where roles were perceived in this fashion, 'value' tended also to be *task-related*. Valuing role *knowledge* in this context, was ascribed only to those deemed to be in a similar position in the individual's hierarchy of professions. One example of this was a registrar in the medical ward who was noted for his 'team director' approach. He was popular with the nurses because he helped out in the ward. However, his beliefs belied his actions. He believed that other professionals 'worked to' him, and that the efficiency and speed with which others operated was what he valued. When asked about people who stood out as effective team members, he described a ward sister whom he had greatly valued because:

> She knew exactly what I wanted, where everything was, and was willing to run around and get it while we sorted this chap out.

This comment suggested the sister's perceived status as one of service to the professionals who did the important work. This was reinforced later in the interview when the doctor was asked about those from whom he had learned. He chose his seniors as the source of his *professional learning and* his learning about *multi-professional working*. This closed approach to learning from other professionals was seen in many who expressed '*directive*' beliefs.

For those of lower status operating within this philosophy it was common for them to reinforce this system by acting as 'receivers of wisdom' in the team. For example, for some of the nurses in the case studies, the effect was to encourage them to behave 'as if' they had little of value to impart to other team members, even where they worked within an integrative culture where learning from each other was part of general team practice.

Those who held an *integrative* philosophy spoke more often about '*working with*' other professionals. For them role-understanding was often related to developing a knowledge of the rationale behind what another professional was doing. In working together they were not only able to see other roles in action but also to learn why those actions were being taken. Extension of this understanding led to the exchange of skills and knowledge, allowing for greater continuity of care to occur.

One example from the rehabilitation case study showed clearly how this practice could enhance therapeutic intervention. A man who was dysphasic, also required physiotherapy to his lower limbs. The PT needed to elicit some communication from the man, and so asked the SLT to join her for the session. By using cueing strategies (for example helping the patient to say the first letter of the first word), the SLT was able to encourage the man to respond where required, helping the PT to work with the patient more effectively. In addition, the PT learned the cueing strategies herself for use in subsequent sessions with the

man, thus ensuring 'carry over' in the absence of other professional input. Role value in this context was therefore related to a more comprehensive picture of the skills and knowledge base with which the professional operated. Furthermore, the willingness to learn from others not only aided individual professional development, but also created a pool of team skills and knowledge.

Those who held an *elective* philosophy were seen to have a limited understanding of others' roles, related more to job description. They also had a strong sense of their own role boundaries. Within the CDAT for example, the clinical psychologists had clear ideas about what they would and would not undertake as part of the team process. Whilst part of this rationale was related to time constraints, they opted not to take part in the joint assessment process where their input could have been extremely valuable. One situation developed which illustrated how maintaining an isolationist stance could hamper other professional input. Two other professionals were attempting to work with a child with severe behavioural problems. After joint assessment they developed a strategy of action which proved not to be successful in keeping the child focused on the therapy session. By chance they discovered that one of the clinical psychologists had been working with the child and could have informed them of more suitable behaviour shaping tactics to use. Her closed professional working and lack of role flexibility therefore constrained the beneficial outcome of this *team's* intervention. Further, team members were not able to learn about the clinical psychologist's practice, nor learn strategies from this professional to assist their own practice.

Implications for education

This paper has shown how the meanings ascribed to team work can shape how people communicate, and what they communicate. They also appear to determine the level of role understanding deemed important, the value assigned to others' contributions, and whether this valuing relates simply to role tasks or sharing professional knowledge and ideas. The description of the ways in which the different philosophies impacted on teamwork is not intended to lead the reader to the conclusion that one philosophy is necessarily better than another, although the reality of a large number of professionals in a team pursuing an *elective* philosophy would not be defined as 'teamwork' by current policy. However, it would be possible to state that where different philosophies clash, team function could be adversely affected.

Furthermore, the paper is not suggesting that *all* members of a team necessarily need to hold one philosophy of teamwork or another. The crucial factor here is that professionals' beliefs are challenged and discussed so that a negotiated way forward is found. This would require a certain level of understanding of team-work processes, and would have implications for the education and training of professionals in order to prepare them for this type of working.

From this research we were not able to identify how individuals came to adopt their particular philosophies. The national survey of shared learning initiatives undertaken as part of this research (Miller *et al.*, 1999) showed that few professional education programmes explicitly address team working issues, and still fewer consider that these might be addressed in a multi-professional educational context.

In the clinical case studies, those who demonstrated behaviours which led to highly collaborative working tended to be from therapy professions such as OT, SLT and social work where group process is addressed in some depth (albeit as a mono-professional venture). Several professionals also described prior experience of this type of working which had convinced them of the benefits of the approach, for themselves and for patients. Unfortunately it was not always possible for them to express their ideas and facilitate others

to work in similar ways in their current teams. Working with non 'team-aware' professionals was seen to create disaffection in three case studies. Although some found small numbers of like-minded individuals who they *could* work with, others left their teams.

One educational approach which may assist professionals to develop 'team awareness', understand other professional perspectives and learn about the benefits of collaborative practices would be a system of *shared learning* between professionals. By this we mean both multi-professional clinical learning, and learning related to team-working. An important question to raise would be at what stage this would be helpful in order to foster a multi-professional approach. It could be argued that an understanding of the *fundamental aspects of team-working* needs to be gained as part of basic professional education, in order to deter professionals from becoming entrenched in the attitudes and behaviours inherent in their own professional socialisation. The introduction of pre-qualification shared learning focusing on the *benefits to patients* of developing a shared vision, good communication, and understanding and valuing each other's roles would be a valuable start.

Second, case based learning, once students have had some clinical experience, would allow specific aspects of patient care to be from various professional perspectives. This would enable students to develop an understanding of other points of view, other rationales for action and how to challenge constructively within a safer learning environment than may exist within the clinical setting.

Given the evidence discussed in this paper it would seem appropriate that a third strand is required. This would be an acknowledgement of the fact that people may have *different constructs of multi-professional working which affect how they interpret aspects of teamwork*. Discourse around these interpretations within multi-professional groups could build on their earlier understanding of teamwork. This would give students the opportunity to confront and then negotiate how these differences could be overcome in the clinical setting. As a consequence it could assist them to participate in more dynamic team-working in their professional practice. It could also provide strategies for those who had difficulty in finding a voice and constrain those whose voice too often dominates the process of care. The means by which education could provide a multi-professional context in which individuals could explore and marry these differences is a challenge which needs to be grasped if a realistic future lies in more collaborative working.

Acknowledgement

This research was funded by the English National Board for Nursing, Health Visiting and Midwifery (ENB).

References

CALMAN, K. & HINE, D. (1995). *A policy framework for commissioning cancer services*. A Report by the Expert Advisory Group for the DOH London HMSO.

DEPARTMENT OF HEALTH (1997, December). *The new NHS: modern and dependable*. London: HMSO.

DEPARTMENT OF HEALTH (1998, September). *A first class service: quality in the NHS*. London: HMSO.

FREEMAN, M. & PROCTER-CHILDS, T. (1998). Visions of teamwork: the realities of an interdisciplinary approach. *British Journal of Therapy and Rehabilitation*, *5*, 616–618.

GLASER, B. & STRAUSS, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. New York: Aldine.

MCGRATH, M. (1991). *Multidisciplinary teamwork*. Philadelphia: Athenaeum Press.

MILLER, C. ROSS, N. & FREEMAN, M. (1999). Shared learning and clinical teamwork: new directions in education for multiprofessional practice. *Researching Education: Professional Report Series*, *14*.

ONYETT, S., PILLINGER, T. & MUIJEN, M. (1996). *Making Community Mental Health Teams Work*. London: Sainsbury Centre for Mental Health.

OVRETVEIT, J. (1990, March). Making the team work. *Professional Nurse*, 284–288.

PEARSON, P. & SPENCER, J. (1995). Pointers to effective teamwork: exploring primary care. *Journal of Interprofessional Care*, *9*, 131–138.

POULTON, B. & WEST, M. (1993). Effective multidisciplinary teamwork in primary health care. *Journal of Advanced Nursing*, *18*, 918–925.

ROLFE, G. (1998). The theory practice gap in nursing: from research based practitioner to practitioner-based research. *Journal of Advanced Nursing*, *28*, 672–679.

SCOPME (1997). *Multiprofessional working and learning: sharing the educational challenge*. The Standing Committee on Postgraduate Medical and Dental Education consultation paper, London.

SIMONS, H. (Ed.) (1980). *Towards a science of the singular*. Paper 10, University of East Anglia: CARE.

STRAUSS, A. & CORBIN, J. (1992). *Basis of qualitative research: grounded theory procedures and techniques*. Newbury Park: Sage.