INTERPROFESSIONAL WORKING IN HOSPITALS: THE CASE OF NEPAL

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A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the Degree of Doctor of Philosophy.

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DEDICATED
TO MY FAMILY

My late father Meghanath Kaini and late mother Bodh Kumari Kaini
(who taught me how to be a survivor at difficult times)

Our daughter Shreya and son Shahil
(for their great understanding)

My lovely wife Yeshu
(for her support and encouragement; and being part of this ambitious journey)

DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of Doctor of Philosophy being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others.

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ABSTRACT

Interprofessional working is an essential part of a health service delivery system. Effective delivery of health services relies on the contribution of health care professionals with different types of expertise. Interprofessional working occurs in all parts of the health system, but it occurs in different ways depending upon the organisational circumstances and the needs of service users.

The aim of the study is to examine how health care professionals collaborate and to assess their perceptions of interprofessional working on health care delivery. This study discusses different sides of professional power, identity and autonomy between medical, nursing and allied health professionals. A power perspective of the theory of professions is followed in order to analyse different perceptions of professionals involved in this study.

A qualitative research case study was used in this study. The fieldwork was conducted in three hospitals in Nepal by using a semi-structured interview schedule. Purposive sampling was used and, altogether, thirty-eight health care professionals participated in the research.

The study suggests that interprofessional working is widely recognised and understood. Health care professionals also valued the relevance of interprofessional working despite the fact that it is a relatively new concept in Nepalese hospitals. This study finds that there were no significant differences found in interprofessional working practices between the three different hospitals in Nepal. It is also observed that interprofessional working is not sufficiently motivated amongst health care professionals and adequate support for it is lacking from all stakeholders. Nurses and allied health professionals are quite critical towards the role of medical professionals because they feel dominated and professionally isolated from the medical staff.

In practice there appears to be various organisational, professional and interpersonal barriers such as lack of education on interprofessional care, interpersonal and communication skills. The study concludes with recommendations to improve interprofessional working in Nepalese hospitals.

Table of Contents

TABLES

FIGURES

Chapter 1: Introduction

1.1 Introduction

Interprofessional working and teamwork are a fundamental part of a health service delivery system. Effective delivery of health care relies on the contribution of health care professionals who are also members of health care professional groups and teams in a defined organisational structure. Health care professionals deliver the care as individuals and as members of the interprofessional care team. Interprofessional care and teamwork in health care organisations are linked with the different groups of health care professionals identified to deliver health care. In the health sector, collaboration between different health care professionals is possible only after defining their roles, team composition and allocation of work which is mutually agreed and shared.

Health care professionals and organisations contribute to health and social care; with every profession and health care organisation having its own purpose, interest and field of specialisation. Health care systems across the world *'depend on health workers working together across professional groups and system boundaries*' (Mickan et al, 2010, p.493). The structure and nature of the health care team varies and depends on many factors such as types of service users, specialties and organisational strategies. The way the interprofessional care team is managed and structured may have a great impact upon the success or failure of the team (Baxter, 2007).

Health care professionals dedicate their time and effort to provide the best possible care to service users and families in order to improve the quality of life, alleviate health issues and improve health conditions. Health care professionals work together in a collaborative manner in various forms. Collaboration involves complex interactions between two or more members of different professional disciplines (Reel and Hutchings, 2007). In a

basic form, health care professionals consult with each other and with their patients or service users about the services needed by their service users. In more complex forms of care, health care professionals work more closely, identifying together with service users what care services are required, who provides them and what adjustments need to be made to the health care plan and management. The WHO (2010) asserts that '*it is no longer enough for health workers to be professional, in the current global climate, health workers also need to be interprofessional*' (WHO, 2010, p.36).

Different disciplines in health care have different philosophies and different problem solving styles. For the benefit of service users and health care professionals, they have to work on the interprofessional care team structure. Each interprofessional care team develops certain rules of operation, certain ways of proceeding to accomplish its task. These may range from unwritten or informal group norms of behaviour to formal written procedural manuals (Duncanis and Golin, 1979). Drinka and Clark (2000) describe that there are various specialties in health care and different types of technical skills to be learnt and knowledge to be acquired in health care. However, there may be overlaps in some of the main bodies of knowledge and skills that underline different health professions. Despite different bodies of knowledge, health care professionals work together in formal and informal structures.

An interprofessional care team can include a medical doctor, nurse, physiotherapist, pharmacist, occupational therapist, dietician, radiographer, bio-medical scientist, social worker, mental health worker, psychologist, speech and language therapist and other health care practitioners. The term health care professionals mentioned in this research refers only to registered health care professionals and they are divided into three main groups – medical, nursing and allied health care professionals. Allied health professionals include other registered health care professionals with the exception of nursing and

medical groups. The categorisation of health care professionals in this study is based on the professional registration system as each professional group has to be registered with their own professional councils, e.g. medical council, nursing and midwifery council and health professions council.

The main purpose of this first chapter is to introduce the research topic and to describe the aims and objectives of the research. Following this, justification for the study will be provided and the importance and relevance of interprofessional working will be explained. Finally, the structure of the thesis and brief outlines of each chapter will be described.

1.2 Aim and Objectives of the Research

The main aims of the study are to examine how health care professionals collaborate and to assess their perceptions of interprofessional working on health care delivery. The objectives of the study are as follows:

1. To identify and analyse factors perceived by health care professionals that support and hinder interprofessional working in Nepalese hospitals
2. To examine the understanding and perceptions of interprofessional working among health care professionals in Nepalese hospitals
3. To assess perceptions of interprofessional working on health care delivery in Nepal
4. To examine professional power perspectives of the theory of professions in relation to interprofessional working

The research questions addressed by this research cover the context of interprofessional working in hospitals and the perceptions of health care professionals in health service delivery in Nepal. In these contexts, the research questions are:

- How do various health care professionals interact and collaborate in Nepalese hospitals?
- Which factors support and hinder interprofessional working between various professionals in teams providing health care services in Nepal?
- How do health care professionals perceive the impact of interprofessional working within interprofessional care teams on the delivery of health care in Nepal?
- How does the professional power perspectives of the theory of professions relate to interprofessional working?

1.3 The Justification for the Study

I have been working in health care organisations over a period of twenty-four years in different managerial capacities in primary care and secondary care setups with various health care professionals including medical, nursing and allied health care professionals. I have witnessed the working patterns, styles and relationships between different professions and within professions. Different health care professionals have their own background, defined roles and responsibilities, codes of practice and expertise. However, all health care professionals have only one objective in terms of the services they offer to patients or service users. The objective of their presence in health care is to offer the best possible service to alleviate or improve service users' health problems. I have personally observed that interactions, communication, interprofessional care and teamwork are a part of their professional life. The interaction between health care professionals can be a

complex process which may involve clinical, social, psychological, human and technical aspects. I found it interesting to observe the interactions between health care professionals when they offer their services to service users. This has an impact on the health care delivery and the way service users are dealt with. This is the first prompt that inspired me to carry out a research in interprofessional working.

I have worked for 14 years in Nepal and ten years in the United Kingdom as a health care manager. The health care delivery systems in Nepal and in the United Kingdom are quite different in terms of health economies and financing, organisational structures for health care delivery, consumer awareness, infrastructures, accessibility of health services, distribution and availability of skilled and trained health care professionals. I personally observed the way health care professionals communicate and interact with each other, the services which are delivered and the focus of the health care system in both health economies. I am directly involved in the management and delivery of health care services, therefore, I easily observed and differentiated some of the interprofessional working practices between health care professionals in both scenarios. I felt there are many things that health care organisations and professionals can learn from each other from the two different health care delivery systems in two opposite locations of the globe. This is the second reason I developed an interest in this subject and it inspired me to carry out research in Nepal in this topic.

There are many benefits of interprofessional working described by many research scholars and authors. Empirical research and studies in developed countries have demonstrated that more positive service user outcomes are achieved by collaborating interprofessional teams (Byrnes et al, 2009; CHSRF, 2006; Nolte, 2005; EICP, 2005; Holland et al, 2005; Dow and Evans, 2005; Pollard et al, 2005; McAlister et al, 2004; Leathard, 2003; Miller et al, 2001; Biggs, 1997; Ritter, 1983)

Some authors and researchers suggest that the advantages of effective interpersonal team collaboration can be significant. The outcome of effective interpersonal team collaboration is improved and better patient care (Leathard, 2003; Miller et al, 2001; Hornby and Atkins, 2000; Payne, 2000; Overtveit et al, 1997). Some of the reasons of better patient outcomes mentioned by those scholars are that collaborative practices and team approaches help the team function better and make appropriate decisions for service users, co-ordinated and integrated action, capabilities to cope with stressful and multifaceted environments, combined skills, knowledge and expertise for dealing with complex health problems and team synergy. Over the years, the need for interprofessional care in hospitals has been stressed (Engel and Prentice, 2013). The concept of interprofessional care and team collaboration has been accepted, adopted and implied by hospitals in most of the developed countries (Drinka and Clark, 2000; Reeves et al, 2009; Field and West, 1995; Fagin, 1992; Henneman, 1995; Engel & Gursky, 2003).

The section above describes emerging evidence that service users are benefiting from the new ways of joint working and interprofessional working. However, I did not find any research conducted to assess the interaction, function and impact of interprofessional working in the Nepalese context and in the developing nations. It shows that there are still no comprehensive studies to examine the nature of interprofessional working in Nepalese hospitals. This does not necessarily mean that interprofessional working is not practised in the developing health economies; it simply means that such practices and their impact on health care delivery have not yet been fully examined and assessed in a systematic way.

The major task before the developing countries is to provide better patient care and to obtain maximum output from minimum input of resources by introducing the concept of interprofessional working in hospitals (Naicker et al, 2003; Sebas, 1994). Further to this,

implementation of the concept of interprofessional care and its perceived impact on the health care delivery have to be assessed in order to find out its effectiveness in developing health economies as well. I strongly believe that this research aims to fill the gap in the field of interprofessional working in Nepalese hospitals. This is the third factor that influenced me to think about carrying out a research on interprofessional working in Nepalese hospitals.

I have been working in the field of service improvement, quality and health care governance in NHS hospitals for the last ten years. I have witnessed many changes over the last decade in the health sector due to emphasis on excellent practice, measurable clinical outcomes, cost containment and continuity of care. These changes are some of the contributory factors for greater adoption of interprofessional care instead of following the traditional model of health service delivery. Moreover, due to the introduction of advanced technologies in health and medical care, rising cost of health care, complex nature of health issues, and well informed patients; I believed that health care professionals need to work together in a smarter way if they want to achieve the delivery of the best health services for their service users. There are various political, social, economic, theoretical and practical factors that support and explain the need of assessing interprofessional working for the improvement of health service delivery. Further to this, health service organisations are now subject to many external factors such as government laws, professional councils' rules and regulations, government's management and financial strategies. Health care professionals are greatly influenced by these changes and factors and are adopting interprofessional working as a part of their professional practices. I think the adoption of interprofessional working by health care professionals as a new way of working has to be assessed in a wider context as discussed above. This is the fourth reason that helped me to think in depth about this topic for research.

I thought about this topic a long time ago as a health care manager. My ideas to carry out this research originated from different aspects of my personal experiences as discussed above. Moreover, the multiple benefits to service users and the nature and complexities of interprofessional working fascinate me to carry out this research on interprofessional working so that collaborative practices between health care professionals can be examined and new ways of working can be proposed. The justification for the interprofessional care concept also comes from the realisation that fragmented health care does not meet the needs of the service users. Interprofessional care requires health care professionals from different professions and organisations to work together to offer the best health service for the benefits of the service users. In this context, the following points justify the reasons for carrying out this study in details.

Learning from Each Other: Concept of specialities and sub-specialties are emerging in health care. Service users are more aware of their treatment and care plans due to easy access of clinical and health care information. New legislations, policies and guidance are published to encourage and boost collaboration between health care professionals and patient engagement. At the same time, there is more literature, training and support available to health care professionals. Different health care professionals such as nurses, doctors, bio-medical scientists, radiographers, pathology technicians etc. are interdependent or associated to each other. Patient care in isolation is impossible as health care professionals and specialities are complementary to one another and are linked to the main body of the health sciences. Health care professionals may also learn from each other. In this context, it is important to understand and assess their perceptions about interprofessional working.

Changing Health Care Scenario in Nepal and South Asia: The size and composition of Nepal's population has changed substantially in the past century and will continue to

change in the coming decades (CBS, 2011). The number of service users who will be demanding health services in Nepal is expected to increase as a result of these changes. Due to the population growth and emerging trends in communicable and non-communicable diseases, there is great pressure on health and hospital services. The proportion of public budget for health service is significant in most of the developing countries. In South Asia from 2005 to 2025, it is projected that the total spending in health will increase by 45 percent, of which 27 percentage points are the result of population growth, and 18 percentage points are the result of age-sex structure changes (Mathers et al, 2006). A huge sum of public expenditure on health care is spent on human resources, especially on clinical staff (WHO, 2012). Therefore, how health care professionals work together with other groups of professionals and how they collaborate need to be assessed from their perspective to examine the impact on health care delivery. Therefore, this study is designed to examine the health care professionals' perceptions of interprofessional working on health care delivery in Nepal.

Shortage of Health Care Professionals: WHO (2010) states that the world is facing a shortage of the health workforce, therefore policy makers are looking for new and innovative ways that can help them develop policy and programme to bolster the global health workforce. Interprofessional working amongst health care professionals is essential to the development of a collaborative practice friendly health work force, one in which all health care staff work together to provide all kinds of services in a hospital (CIHC, 2009).

It may come as no surprise that developing countries in the world are served by fewer health care professionals. Therefore, they need effective and new ways of joint working and collaborative practices to serve the entire population by fewer health care professionals. Another issue that contributes to the shortage of health care workers is that

health care professionals often leave their home countries in order to practise in more lucrative areas overseas, mostly in developed countries. The health care system of developing countries have been badly damaged by the migration of health care professionals to developed countries (Naicker, 2009). The joint working and interprofessional working could be a way for managing scarce human resources in developing countries. Therefore, this study aims to examine understanding of, and perceptions of interprofessional working among health care professionals in Nepal.

Importance of Interprofessional Working: According to Miller et al (2001), interprofessional working brings many benefits to service users, carers and the professional team. Miller et al (2001) state that interprofessional care teams bring many benefits to service users such as consistency and continuity of care, a reduced number of ambiguous messages, appropriately and timely referral, actions resulting from a holistic perspective, and problem solving. These benefits are also acknowledged and appreciated by health care professionals and helps to promote a high level of commitment to the concept of collaborative practice (Casto and Julia, 1994).

The Health Professions Regulatory Network (2008) states that advances in technology, complex health issues, rising patient awareness levels, knowledgeable health consumers and an aging population are but a few of the reasons why health care professionals need to work together more effectively and efficiently if they are to continue to achieve the best health outcomes for their service users. Therefore, a new model of health care incorporating interprofessional working is useful to deliver quality health services. In the context of importance of an interprofessional team, Engel and Prentice (2013) state:

> '*The importance of interprofessional teams to access is clearly tied to the primary health care principle of sustainability and affordability. Interprofessional teams are seen to enable better matches between patient need and provider expertise, rather than the*

traditional hospital and physician driven system through which all patients entered, regardless of whether they needed medical services or not'.

(Engel and Prentice, 2013; pp.428-429)

Interprofessional working is the best platform for discussing service users' health problems and issues and those issues are considered and discussed from a number of different clinical and professional perspectives (Hawley, 2007). Furthermore, these can complement each other to offer the best, flawless and continuous health services so that health care professionals can learn from each other and they can keep service users satisfied at all times (Haire, 2010). According to the Institute of Medicine's (2011) report *'Allied Health Workforce and Services – Workshop Summary'* thousands of health care professionals representing a variety of disciplines make up the allied health workforce and the alliance of health care professionals helps improving the care of service users. According to Street and Blackford (2001), teamwork positively influences service users' outcomes. Service users see opportunities and potentials to draw on health care professionals' areas of knowledge and experience as the health care system prepares to see the effect of the restructure in the health system. The need for interprofessional team working is not a criticism of differentiation within and between health care professionals based on proper task differences, but this is an essential feature of professional life (Hudson, 2002).

The points above describe the importance of interprofessional working and give a clear rationale for choosing this topic for carrying out this study in Nepal. This research will therefore examine how health care professionals collaborate and to assess their perceptions of interprofessional working on health care delivery in Nepalese hospitals.

1.4 Structures of the Thesis

Following on from the introduction, aims and objectives and rationale of the research discussed in the first chapter, the second chapter details the literature review. The literature review is broadly focused on four themes – firstly the concept of interprofessional working; secondly the structural aspects of interprofessional working including team structures, roles, responsibilities, skills and competencies of health care professionals; thirdly; communication, leadership, decision making, professional identity, autonomy and boundaries; and, finally clinical outcomes and impact on health systems, and challenges and barriers of interprofessional working.

The third chapter outlines the theoretical perspectives of a professional power approach of the theory of professions. The purpose of this chapter is to demonstrate the understanding of professional power perspectives on professions and to explain the reason for choosing the approach. Therefore, it starts with the justification of choosing professional power as the main theoretical concept of professions for this study. This chapter also describes the theory of professions and the professional power approach of professions including the critical analysis of the professional power perspectives of the theory of professions.

The fourth chapter discusses in detail the methodological choice and the research design of the study. The fourth chapter provides clear rationales for the research design and describes the reasons for the choices of the methods used for the study, including likely benefits, weaknesses and barriers of the strategy. Furthermore, the fourth chapter gives details of the research methodology including research design, sample, reliability, validity, data analysis approaches to be used, ethical considerations, data collection and analysis methods to be used.

The fifth chapter describes the health care and education system in Nepal. It starts with a brief country profile of Nepal, then a detailed description on how health services are managed and organised in Nepal is presented. It gives a brief synopsis of health services delivery by public, private and voluntary sectors in Nepal. A brief discussion on medical, nursing and allied health care professionals along with the education system and regulatory bodies in Nepal is presented. Finally, interprofessional working in the Nepalese context is also discussed in this chapter.

The sixth chapter is about findings of the study in relation to interprofessional working in Nepalese hospitals. Data collected from interviews with health care professionals are analysed to examine how health care professionals collaborate and to assess their perceptions of interprofessional working on health care delivery.

The seventh chapter is the discussion. This chapter discusses the perceptions of interprofessional working among health care professionals and examines power perspectives of the theory of professions in relation to interprofessional working. This chapter reflects on the results of the study in terms of the research aims, objectives and research questions. This chapter also discusses the results obtained from the interviews and analysis of the documentary evidence and compares it with other research. This chapter critically examines professional power perspectives in the context of literature on interprofessional working and professional power approach of the theory of professions.

Finally, the eighth chapter summarises the findings of the study and discusses the ways to improve interprofessional working in Nepalese hospitals. This chapter discusses the contributions to knowledge made by this research. Moreover, this chapter recommends various ways to improve interprofessional practice in Nepal. Limitations of the study are explained in this chapter. Finally, areas for further research in this field are identified and suggested at the end of this chapter.

Chapter 2: Literature Review

2.1 Introduction

Interprofessional care is not only an approach of collaborative practice between health care professionals; it is also a process of learning and working. Being interprofessional is about collaborating in ways that are fit for purpose and is a means of improving practice or service delivery (Hammick et al, 2009). The overall goal of providing efficient and effective care is a shared aim between health care professionals and their teams. Health care professionals need to share a common vision and goal, communicate clearly with other members of the team, understand their roles, trust one another and make decisions as a group (Nolte, 2005). Health care professionals, service users and health systems can benefit from diverse health care professional groups when their attitude and practices are aligned with the common goals and objectives. The effectiveness of interprofessional care teams can be evaluated in many ways by service users, health care professionals and other stakeholders in terms of clinical effectiveness and health care outcomes on a continuing basis or a series of snapshots at regular intervals.

This chapter deals with the literature review and evaluative summary of studies and research found in the literature related to interprofessional working. The main objectives of the literature review are to give a clearer understanding of the main themes of the study and to describe, summarise, evaluate and clarify any research already carried out in the field of interprofessional working in a health care setting. The literature review helps to identify any questions or gaps around the knowledge of interprofessional working. The literature review is broadly focused on four themes – firstly, the introduction and structural aspects of interprofessional working including team structures, roles and responsibilities as well as skills and competence of health care professionals; secondly

communication, leadership and decision making in interprofessional working; thirdly professional identity, autonomy, boundaries; and finally impact, challenges and barriers of interprofessional working.

The following sections in this chapter describe the views from existing literature on interprofessional working in health care which has an impact on team effectiveness and performance. Furthermore, the literature review emphasises that interprofessional working improves health care outcomes and is beneficial to service users, health care professionals, health systems and organisations.

2.2 Concept of Interprofessional Working

2.2.1 Defining Interprofessional Care

Research scholars have explored interprofessional care, teamwork and collaborative practice in health care organisations and there is much literature published on this topic. From the literature review on interprofessional working, the term 'interprofessional care or working' has been defined in many ways and there is no agreement about the meaning of the term. Pietroni (1992) describes that different people can interpret the term ‘interprofessional’ in different ways and that it may mean different things to different people which may be influenced by their background, identity, thoughts and languages. In health care, teams have been variously described and discussed as multidisciplinary, interdisciplinary, intradisciplinary, intraprofessional and interprofessional. Various authors, scholars and researchers have used these terms to represent joint working or working together in health and social care. The use of these terms and random attempts to draw a clear demarcation between them has, at times, led not to clarification but to even greater confusion.

The terminologies used in this field have been debated for a long time. Pollard et al (2005) argue that various terms such as multiprofessional, interprofessional, multidisciplinary, interdisciplinary, multiagency and interagency are being used to describe what appear to be similar phenomena. The degree of interaction and mutual dependency among health care professionals, and responsibility of health care professionals for service users describe the difference between three terms – 'multi',' inter' and 'trans' (Kvarnstrom, 2008). According to Payne (2000) multi-professional, multi-disciplinary and multi-agency work imply, respectively, that several professional groups, various knowledge and skill bases and different agencies are drawn together in a structure to provide service and inter-professional, inter-disciplinary and inter-agency work imply, respectively, that professional groups make adaptations in their role to take account of and interact with the roles of others, they similarly adjust those knowledge and skill bases and agency responsibilities. Rawson (1994) defines three terms *inter, trans and multi* as:

> *'The prefix 'inter' denotes relationships both between and among the elements and further implies some notion of reciprocal operations. 'Trans' signifies relationships across or beyond but does carry any indication of mutuality. 'Multi' implies many and some form of composition but again does not immediately suggest any give and take'.*
>
> (Rawson, 1994; p.40)

Rawson's definition above of these three terms have been further clarified by D'Amour et al (2005) and they state that several different professionals work on the same project independently or in parallel in multidisciplinary team, whereas interdisciplinary team is a structured entity with a common goal and decision making process based on an integration of the knowledge and expertise of each professional. They argue that a

transdisciplinary team is a type of professional practice of consensus seeking process in which opening of the professional territories plays a major role and the boundaries become blurred or even vanish.

The prefix ‘inter’ tends to imply collaboration, particularly in areas such as decision making (Overtveit, 1997; Payne, 2000 and Pollard et al, 2005). The prefix ‘inter’ relates to the dimension of ‘collaboration’ (Kvarnstrom, 2008). Leathard (2003) states that:

> ‘*While for some, ‘inter’ means working between two groups only, so for them ‘multidisciplinary’ or ‘multiprofessional’ are preferable forms to denote a wider team of professionals. For others, the term ‘interprofessional’ is the key term that refers to interaction between the professionals involved, albeit from different backgrounds, but who have the same joint goals in working together. ... Latinists can help to simplify the arena by translating ‘inter’ as between; ‘multi’ as many; and ‘trans’ as across. What everyone is really talking about is simply learning and working together’.*
>
> (Leathard, 2003, p.5)

Pecukonis et al (2008) argue that multi-disciplinary team members work independently with client systems in parallel and may or may not share information formally; and interdisciplinary team members work in a collaborative and integrated way and utilise interdependent knowledge, skills, attitudes, values and methods. Duncanis and Golin (1979) state that if a team is composed of several members of the same profession, it is referred as intraprofessional, whereas if a team is composed of members of various professions and co-operate across disciplines, interprofessional might be used to describe the practice. The two terms 'multi-disciplinary' and 'multi-professional' are being used interchangeably in health and social care. A team of different health care professionals

invariably provide treatment and care to service users in health and social care settings. According to Hawley (2007), this team approach is known as multi-professional as it involves two or more academic disciplines or professions. Hawley further states that when multi-professional teams change their working relationship with other professionals, then it becomes interprofessional. From the above literature, it is clear that different terms are being used to define joint working and the term interprofessional involves learning from each other about their roles in a collaborative relationship to provide effective health services to service users, which is further discussed in the following section.

Interprofessional is a broad term, which can be used and implemented in many fields such as health care, education, social care and so forth. Finch (2000) defines interprofessional as '*a professional's skills, knowledge and roles which are adapted to fit in with other professions*' (p.1138). Interprofessional can also be applied at all levels of professional lives from the beginning of a career as a student or a trainee to the senior level professionals who set policies or lead health care organisations (Hammick et al, 2009). Hammick et al suggest the following points as clues to the meaning of interprofessional:

- *'Not something you do alone: it involves being with others/colleagues*
- *Not just for students: it is also for practitioners*
- *Not only planned: it can be spontaneous*
- *On the campus, in the classroom, in the workplaces and workspaces*
- *The learning processes are not the end: they are the means towards an end*
- *Having an end implies there is a purpose: to improve collaboration, the quality of care and make gains in professional practice*

- *The focus on professional practice links the learning with working'*

(Hammick et al, 2009; p.10)

Interprofessional care is specifically applied in a health and social care context. It is an important approach which is applied regardless of place and time and applies in novel and routine contexts. Haire (2010) defines interprofessional care as a process whereby health services are provided to patients by multiple health care givers who work collaboratively to deliver quality care. Pollard et al (2005) describe that one way of describing interprofessional care is in terms of the effectiveness of co-ordination, collaboration and communication. These two definitions are more focused on the delivery of quality care and effective health services. Many other research scholars and authors have defined interprofessional care in health care services as a process that enables interaction, communication, teamwork, knowledge and skill sharing between different professionals to deliver quality health service to service users. For instance, Hornby and Atkins (2000) focus on the process side of interprofessional care and define it as the process for providing the best health services to service users and helping to achieve the optimal desired outcomes and service users' satisfaction. Hammick et al (2009) describe being interprofessional is 'learning and working' or 'working and learning' with others as appropriate or when necessary. Drinka and Clarke (2000) argue that interprofessional team members work collaboratively to assess and solve service users' problems beyond the scope and skill of a particular group of health professions.

The Health Force Ontario (2007) defines interprofessional care in its report '*Interprofessional Care: A Blueprint for Action in Ontario*' and states that it is '*the provision of comprehensive health services to patients by multiple health caregivers, who work collaboratively to deliver quality care within and across settings*' (p.7). The Health Force Ontario (2010) further states that interprofessional care is '*a collaborative, team-*

based approach to providing optimal patient care which benefits and empowers patients, as well as significantly improving health care provider satisfaction' (p.5). According to Carlton (1984), the most accurate way of describing what most helping health care professionals have in mind when they talk about joint working with other health care professionals is interprofessional. Harbaugh (1994) agrees and states that professionals who work together, with intention, mutual respect, and commitment, for the sake of a more adequate response to a human problem are working interprofessionally.

Ovretveit et al (1997) differentiate the term 'interprofessional' with 'multidisciplinary' and mention that interprofessional working is a broader subject than multidisciplinary teamwork and interprofessional working is organised within multidisciplinary teams. They define interprofessional working as how two or more people from different professions communicate and cooperate to achieve a common goal and it ranges from, at one extreme, making a referral to another professional, through increased closeness of working to making a joint assessment, working together as co-therapists, or working as an operating room team (Ovretveit et al, 1997).

Different authors and scholars mention different features of interprofessional care. For example, Harbaugh (1994) describes common objective, separate skills or professional contributions and a proper system of communication as three elements of interprofessional working. The Health Force Ontario (2010) mentions wider points and suggests that building the foundation, sharing the responsibility, implementing systematic enablers (providing systems, process and tools that will allow interprofessional care to be taught, practised and organised) and leading sustainable change are frameworks for effective interprofessional care (HFO, 2010).

Interprofessional working goes beyond interprofessional care. In this context, Hoffman et al (2007) define interprofessional working in health care as ‘a patient centred, team based

approach to health and social care and it is through this synergy that the strengths and skills of each contributing health and social care worker is maximised, thus increasing the quality of patient and service user care'. Various authors (Hornby and Atkins, 2000; Payne, 2000; Overtveit et al 1997; Leathard, 2003) describe that interprofessional working in health care can take place in many forms such as formal or informal teams, ad hoc or work groups, review groups, clinical teams, management teams, multi-disciplinary teams and so forth. Thus, the concept of interprofessional working can be described in many ways (D'Amour et al, 2005; Willumsen, 2006).

The term 'interdisciplinary' is also used to denote joint working in health and social care. Minore and Boone (2002) state that interdisciplinary is understood to be between and among professionals. Farrell et al (2001) go further than that and describe interdisciplinary health care teams as a group of colleagues from two or more disciplines who co-ordinate their expertise in providing care to patients. Orchard et al (2005) voice a similar opinion and argue that the main aim of an interdisciplinary team is to pool expertise with an assumption that the health services will be more effective and efficient. In this sense, 'interprofessional' and 'interdisciplinary' have many common features. Therefore, many researchers and scholars use both terms 'interdisciplinary' and 'interprofessional' interchangeably.

One of the challenges of interdisciplinary health care practice is ensuring clear definitions of the health care professionals' roles and expectations with regard to shared care and objectives. Farrell et al (2001) argue that health care professionals in an interdisciplinary health care team meet regularly, discuss each service user they exchange information with, analyse the service users' problems, develop a treatment plan, and co-operate in its implementation.

The term 'interdisciplinary working' in health care is defined in a similar way as the term 'interprofessional working' is described. For instance, The Canadian Association of Occupational Therapists (2005) defines interdisciplinary working as 'a positive interaction of two or more health professionals, who bring their unique skills and knowledge, to assist patients/clients and families with their health decisions'. Bronstein (2003) describes five components that constitute interdisciplinary working between social workers and other professionals: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. Bronstein's 'Model for Interdisciplinary Collaboration' consists of four influences on collaboration - professional role, structural characteristics, personal characteristics and a history of collaboration (Bronstein, 2003).

In summary, it is clear that different authors and scholars use different terms to describe joint working, interprofessional care and collaborative practice in health and social care. One of the gaps in literature is that existing literature is not clear about the use of a specific term for a different team. Therefore, different terms are used to describe the same team process which creates confusion when attempting to recognise the team process and stages for different types of teams (e.g. interprofessional team, multiprofessional team and interdisciplinary team). To date, 'interprofessional working' seems the strongest term to describe working together by pooling health care professionals' skill, knowledge and practice; and by sharing professional viewpoints to make joint decision for the benefits of service users, health care professionals, system and organisations. The section below further discusses the concept of interprofessional working and its elements, attributes and features in a broader context in health and social care.

2.2.2 Interprofessional Working

Interprofessional working was used by the World Health Organisation (WHO) in its Alma Ata declaration in 1978 in the context of primary health care and acknowledged that interprofessional working was essential to ensure the success of primary care (WHO, 1978). This was further initiated by developing national policies and guidelines in Northern America, the United Kingdom and Europe to define the concept and identify techniques to best incorporate it into practice (Petri, 2010). Walsh et al (1999) state that it has only been within the last few decades that health care professionals and professionals from a number of other professions including education, psychology, law, social work, nursing, and health have recognised the need for interprofessional working in a wide range of practice settings.

Different terms such as 'collaboration', 'interprofessional working', 'teamwork', 'joint working', 'partnerships' etc. have been used inter-changeably in health and social care to describe the joint or team working practices amongst various health care professionals. Biggs (1997) states that joint working involves multi professional or interprofessional teams, where members from different health care professional groups agree to work together for a specific task or project. Collaboration is used as a generic term to denote the joint working practice among and between different health care professionals. It is confusing to define the term 'collaboration' as there are no concrete definitions within health service literature to clarify the concept. In collaboration, two or more individuals, teams or agencies work together for a particular task or project by sharing their expertise to achieve the optimal desired outcome (CHSRF, 2006). However, the NHS Executive (1998) says that the term is used most of the time in policy context to promote the term 'joined-up working or thinking' so that the health services can be delivered flawlessly.

According to Health Canada (2005), collaboration is focused on the needs of service users; enabling them to be partners in their care, with the most appropriate health professionals providing the services required to meet their health care needs. The CHSRF (2006) defines collaboration in a broad sense and describes it as '*a process that requires relationships and interactions between health professionals regardless of whether they are members of a formalised team or a less formal or virtual group of health professionals working together to provide comprehensive and continuous care to a patient/client*' (p.4). Way et al (2000) agree and state that collaboration involves working relationships and ways of working that fully utilise and respect the contribution of all providers involved (Way, Jones and Busing; 2000). Similarly, Hornby and Atkins (2000) define collaboration as a relationship between two or more people, groups or organisations working together to define and achieve a common purpose.

The term 'collaboration' is defined within the clinical and health care context as well. Baggs and Schmitt (1988) define the term 'collaboration' in nursing and medicine within the context of an intensive care unit. They stated that 'nurses and physicians co-operatively working together, sharing responsibility for solving problems and making decisions to formulate and carry out plans for patient care'. D'amour et al (2005) describe the term collaboration in the context of health care and state that the term collaboration conveys the idea of sharing and implies collective action oriented toward a common goal, in a spirit of harmony and trust, particularly in the context of health professionals. The CIHC (2010) asserts that interprofessional working occurs when health care professionals, service users, families and communities develop and maintain interprofessional working relationships that enable optimal health outcomes. The WHO defines collaborative practice in health care as the following:

'*Collaborative practice in health care occurs when multiple health workers provide comprehensive services by working together synergistically along with patients, their families, carers and communities to deliver the highest quality of care across settings'*.

(WHO, 2010; quoted in Mickan et al (2010) p.494)

Zwarenstein et al (2009) focus on the process side of collaborative practice and state that interprofessional working is the process in which different health care professional groups work together to positively impact health care. According to Zwarenstein et al, it involves a negotiated agreement between health care professionals which values the expertise and contributions that various health care professionals bring to patient care. Similarly, Way et al (2000) agree with this statement and define interprofessional working practice as '*an interprofessional process for communication and decision making that enables the knowledge and skills of care providers to synergistically influence the client/patient care provided*' (p.3). The Health Force Ontario (2010) states that interprofessional working is linked to the concept of teamwork.

Without a doubt, interprofessional working has been seen as a means of improving the outcome of health services. Hansen and Nohria (2004) state that interprofessional working is a great tool for the advancement of ideas and innovation. Similarly, Hudson (2002) states that an interprofessional care approach has been seen as a way forward and the best practice to overcome disintegrated practice in health care. According to the CIHC (2009), it is not only limited to competitiveness in the global economy, but also plays a big role in advancing knowledge and understanding of health services management and improving the effectiveness of a health care delivery system (p.21). Furthermore, Way et al (2000) highlight the importance of collaboration and state:

'Collaboration is a way of working, organising, and operating within a practice group or network in a manner that effectively utilises the provider resources to deliver comprehensive primary health care in a cost efficient manner to best meet the needs of the specific practice population. Successful collaboration benefits patients, providers and the health care setting'.

(Way, Jones and Busing, 2000, p.3)

Different authors and scholars have described various attributes and elements of interprofessional working. Way et al (2000) mention seven essential elements for a successful interprofessional working - responsibility and accountability, co-ordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect. Similarly, Carnwell and Buchanan (2005) describe joint working, team-work, intellectual and co-operative endeavour, participation and planning in decision making, sharing of expertise, non hierarchical relationship, trust and respect in collaborators and willingness to work together towards an agreed purpose as the attributes of interprofessional working. Wells et al (1998) suggest that open communication, co-operation, assertiveness, negotiation and co-ordination are the five major attributes relating to interprofessional working. Liedrtka and Whitten (1998) highlight shared values, trust and personal engagement as important attributes for cross-disciplinary collaboration, whereas Fewster-Thuente and Velsor-Friedrich (2008) mention shared power based on knowledge, authority of role, and lack of hierarchy as an attribute of collaboration. Henneman et al (1995) describe that competence, confidence, commitment, respect, trust, patience, nurturance and time are important attributes required to build a successful relationship so that interprofessional working can occur. Likewise, Petri (2010) states that interprofessional education, role awareness, interpersonal relationship skills, deliberate action and support are the elements that must be in place before interprofessional working

can be successful. These attributes are not specifically mentioned as a word that relates to a particular team or type of health care setting, but give a clear idea about the interprofessional working and its characteristics in general terms in health care settings.

From the organisational point of view, interprofessional working encourages professional boundaries, shared authority and decision making based upon cooperative values (CIHC, 2010). Theoretically, interprofessional working is based on professional skills and expertise (Zwarenstein et al, 2009) rather than assigned roles and responsibilities. Therefore, it can be concluded that interprofessional working is not only a way of working, but it also has a strong influence on the way health care organisations are run and health system policies are developed.

The Canadian Interprofessional Health Collaborative (2010) states that interprofessional working requires trust, mutual respect, availability, open communication and attentive listening – all characteristics of interprofessional care collaborative relationships. Similarly, Way et al (2000) state that the objectives of interprofessional working are achieved if all health care professionals work together, respect and understand each other's roles, responsibilities and skills. In line with the statements above, Reel and Hutchings (2007) suggest that working effectively in a successful interprofessional care team involves understanding and acknowledging each other's roles, being a willing participant, having all required competence and confidence, open and effective communication, trust and mutual respect, shared power and support from senior management (p.151).

According to the WHO (2010), there are three mechanisms to support interprofessional working and collaborative practice in health care - institutional support mechanisms (i.e. governance models, structured protocols, shared operating resources, personnel policies, supportive management practices); working culture mechanisms (i.e. communications

strategies, conflict resolution policies, shared decision-making processes); and environmental mechanisms (i.e. built environment, facilities, space design). These three mechanisms may help health care professionals to determine the actions they take to support collaborative practice and to achieve shared goals and optimal desired outcomes.

Similarly, various other research scholars and authors mention different factors that support interprofessional working. Whitehead (2001) examines various issues on nursing's hesitancy in adopting interprofessional working practices and argues that nurses need to acknowledge service users as equal contributors and partners of the team and they need to be aware of the ranges of teams and agencies involved to promote interprofessional working practices. Furthermore, Whitehead emphasises that better education, training and shared learning are essential factors that help to improve interprofessional working. Similarly, Schmalen et al (2005) mention trust, respect, shared leadership, recognition of unique contribution, collegiality and open communication as enabling factors for interprofessional working. These are generic factors which claim to support interprofessional working found in the literature. However, the literature does not suggest specific factors applicable to a particular health care setting or hospital.

In summary, interprofessional working is collaborative working in which health care professionals share the common purpose of developing mutually negotiated goals which are achieved through an agreed care plan, management and procedures (Payne, 2000, Leathard, 2003, Colyer, 2012). Interprofessional working goes beyond team and professional boundaries and connections. Highly prioritised health issues such as patient safety, quality of care, access to services and the health workforce exceed the borders of health care professions and disciplines (CIHC, 2009). Thus, identifying that no single group of health care professionals and team can effectively sort out health system problems of an entire population or a community concern has prompted widespread

reflection and dialogue about how we can collaborate to build and mobilise the knowledge that benefits service users and the public (WHO, 2006). Sullivan (1998) describes that health care professionals from various disciplines establish collaborative practices among themselves and with other professionals or colleagues from other specialties on individual or organisational level. An important aspect of interprofessional working is to have a number of qualities, such as shared goals, recognition of others roles, team structure and leadership (CIHC, 2010). The following section in this chapter examines the role of health care organisations and team structures for interprofessional working.

2.3 Health Care Organisations and Interprofessional Team Structures

Health care teams operate and function within and between organisational settings [Agency for Health care Research and Quality, (AHRQ), 2012] and the parent organisation provides the support system for the team's operation (Duncanis and Golin, 1979). D'Amour and Oandasan (2005) agree and state that organisational mechanisms can shape the way a team of health care professionals work collaboratively, creating synergy instead of fragmentation. Hall (2005) suggests that health care professionals participating in interprofessional working need clear organisational structures, shared protocols, guidance and procedures. Similarly, Kane (1983) mentions that adequate resources, appropriate systems and resources are required for interprofessional care at organisational level.

Health care organisations are responsible for effective delivery of health services. They play a vital role in the process of social development, which can be improved by interprofessional care (Hamidi and Eivazi, 2010). Health care professionals must be aware of organisational factors that may have influence their performance and professional growth (Latella, 2000). Many researchers suggest that organisational factors

have a great impact on the development of interprofessional a health care team and its performances (Hairy, 2012; D'Amour et al, 2004; Sorbero et al, 2008 and Wall, 2003). Other researchers have confirmed that organisational culture and structures directly and indirectly influence interprofessional care and team outcomes (Pina et al, 2008; Odegard, 2005; Glasby and Dicknson, 2008; Casto et al, 1994). The CHSRF (2006) states that health care teams thrive when they work in a favourable environment that supports and promotes interprofessional care and teamwork. Therefore, in the context of health care organisation, it is an important factor to note that interprofessional working is the life line to achieving shared goals and desired optimal outcome (Xyrichis & Iowton, 2008).

Drinka and Clark (2000) argue that health care organisations should develop vision, strategies and action plans that enable culture shifts required for interprofessional care and teamwork. The Health Professions Regulatory Network (2008) goes further and states that senior management and clinical leaders need to ensure the availability of required resources and infrastructures to facilitate staff training and development, effective and ongoing communications, and the development of relevant policies, protocols and guidelines. Interprofessional working can play a vital role in mitigating some of the challenges faced by health care organisations (Schmitt, 2001). In this context, Pearson and Spencer (1997) highlight that appropriate organisational structures, culture and environment help hospitals to move forward towards strengthened health care teams, and ultimately, improved health outcomes for service users and the health care teams. Furthermore, the organisational contexts within which health care professionals work influence the structure of the team and also constrain or enhance the possibilities of interaction (Miller et al, 2001).

Teams cannot function without a clearly defined structure (Baxter, 2007). According to the Agency for Health care Research and Quality (AHRQ, 2012), understanding the

structure of a health care team is important and it is the first step in order to learn how to promote teamwork and creates conducive environment to effective team functioning. It further asserts that such an environment is based on various factors such as 'a commitment to collaboration, mutual accountability, acknowledgement, recognition, and professional respect'. Hall (2005) confirms that interprofessional care team practices are influenced by the team structures and enabling team practice development encourages team culture (Hall, 2005). Miller et al (2001) agree and describe that the degree of interaction and interprofessional working across health care professionals and team structures would have a considerable impact on the team performance. Likewise, O'Leary et al (2010) claim that the outcome and quality of teamwork depend upon the positive contributions from members of the team.

According to Griffiths (1997), the roles, responsibilities, flexibilities and accountabilities in the team are defined in the team structure. Similarly, Leggatt (2007) argues that knowledge and skills mix are also considered when structuring a team. Any health care professionals may be included in the interprofessional care team depending upon the nature of the task of health care delivery, the skills required and the specific needs for patient care (Kaini & Veersma, 2013). Consciousness and accountability for professional action in interprofessional working is now a much sharper focus in the team structure (Hammick, et al, 2009). In this context, Payne (2000) suggests that understanding why teams are structured, how they function, knowing the role of the team members, team types and skills required are vital for effective teamwork and collaborative practice.

Tuckman (1965) developed 'Team Development Model' which is considered a foundation for the definition of team development. Tuckman's model has been the most used and influential concept of team development over the last few decades. Tuckman and Tuckman and Jenson (1977) reviewed more than 70 studies of team development and

they conceptualised four stages of team development - forming, storming, norming and performing. The forming stage is the testing and dependency stage; the storming stage is the conflicting stage; the norming stage is the stage of cohesion and consensus; and the final performing stage is the functional stage and roles are finally related to the task. Farrell et al (2001) criticise this model and state that this team development model is just a description of common features of a group structure and lacks clearly defined constructs and propositions relating the constructs to one another.

At the start of team formation, defining team membership for an interprofessional care team is one of the next important steps (Latella, 2000). Overtveit (1997) argues that apart from professional expertise and skills, personal aspects of each member are important factors to consider when forming an interprofessional care team. Secondly, setting team protocols to define how team members work together, how they make decisions and how they function are equally important aspects of team formation and membership (Engel, 1994). Nolte (2005) states that the composition of the health care team depends on the nature of service users being served and the environment in which the team is functioning. As health care is not static, the team membership can be changed depending upon the need of the service users and the nature of the clinical task (Kane, 1983). Team members should be able to adjust within the team and they need to respect and value each other and service users within the department (Church, 1998).

Understanding how team developmental processes can affect health care team members, overall team functioning, and outcomes of interprofessional care and teamwork is an important part of being an efficient and effective team member (IPEC, 2011). Leggatt (2007) states that where patient outcomes are dependent on effective interdisciplinary teamwork, there is a need for good preparation of health professionals in teamwork. Similarly, Drinka and Clark (2000) claims that health care organisations that promote,

support and facilitate teamwork and collaboration improve the quality of care, reduce issues relative to workplace stress and will realise significant systemic benefits.

Finch (2000) describes that health care team members do not hold or share the same education, skills and knowledge. Similarly, Engel (1994) states that they belong to different professions each with its own body of knowledge, skills and attitude (p.65). Therefore, health care professional team members are equipped with a set of complementary skills to offer high quality health services to service users (Leggatt, 2007). Members of the interprofessional care team are interdependent and they share authority and responsibility among team members to achieve a common goal and optimal desired outcomes (Rafferty et al, 2001). Church (1998) states that health care team members are assigned specific roles to play according to their skills, knowledge and capability. The following section 2.4 gives an overview of health care professionals' competency, roles and responsibilities in the context of interprofessional working.

From the sources above, it is clear that organisational factors have great impact on the development of interprofessional working and organisational context influence the structure of interprofessional working. The literature suggests that the success and failure of interprofessional working in health care organisations is widely measured at the organisational level rather than the team level. Therefore, health care professionals should be aware of organisational factors to work effectively in an interprofessional care team. Furthermore, it can be concluded that the outcome of interprofessional working is influenced by team structure. The literature above suggest that if health care organisations promote, support and facilitate interprofessional working, then these factors have positive impacts for improving the quality of health care and reducing issues related to workplace stress. The sources and research findings mentioned above are from developed health economies. However, the role of health care organisations and team structures for

interprofessional working in developing countries has not been discussed and examined in the current literature. It is also clear that team membership and involvement are based on skills, competencies, expertise, experience and capabilities. Section 2.4 below describes various aspects of the competencies and skills required for various roles in interprofessional care teams.

2.4 Health Care Professionals' Competencies, Roles and Responsibilities

Every profession has its uniqueness and may require certain sets of skills, competencies, knowledge and clinical abilities. It is natural to expect health care professionals to be skilled, capable and expert in their fields of expertise or specialties and that they interact with various different professions for effective delivery of health services. The term competency is used to describe the knowledge and skills required to be able to perform a specific task whereas interprofessional skill is the capability to work together and collaborate with other professions and to understand others' tasks, roles and responsibilities. Norman (1985) states that a competency is more than knowledge; it includes the understanding of knowledge, clinical, technical and communication skills, and the ability to problem-solve through the use of clinical judgment. Likewise, Rawson (1994) states that competencies are thought to make up a basic stock or toolkit of knowledge and skills required for professional development.

Different authors and scholars define interprofessional competency in different ways, and link it with skills and abilities required for joint working. For instance, the Health Force Ontario (2007) describes interprofessional care competency as '*the understanding and application of clinical knowledge, clinical skills, interprofessional care skills, problem solving, clinical judgement and technical skills*' (p.44). Similarly, Barr et al (2005) define interprofessional competence as '*the ability to collaborate with other professionals, to know and understand the importance, functions and roles of others in their profession*'

(Barr et al, 2005 quoted in Wilhelmsson et al, 2012*;* p.85*).* The Canadian Interprofessional Health Collaborative (2010) suggests that competencies are developed for health care professionals as a way of developing and capturing the knowledge, the skills, and the attitudes and behaviours required to be a successful practitioner in their profession (p.7).

McCallin (2005) argues that health care professionals cannot assume that they have all skills and attributes required for interprofessional working. Developing those skills and practices may require commitment to engage in shared learning and dialogue. Norman (1985) argues that health care professionals are responsible for developing interprofessional care competencies and delivering safe and effective health care services. Whilelmsson et al (2012) stress that to identify and deliver the best quality of care for the service users, health care professionals should be both professionally and interprofessionally competent. They further highlight that personal, professional and interprofessional competencies are the key precondition or foundation for successful interprofessional working. Furthermore, in order to ensure success, members of an interprofessional care team have to be selected carefully for the complementary skills and expertise and the team members need to focus on and be committed to a team goal (Nahavandi, 1997).

Evans (1994) suggests that each health care professional must have well developed knowledge and expertise in their clinical field to contribute as a member of the interprofessional care team. Sullivan (1998) argues that knowledge, skills, expertise and competencies are the basic foundations to the ability to engage in a collaborative practice. Collaborating members of a health care team have very cohesive relationships; they are comfortable working with others and have an appreciation of one another (CIHC, 2009). Natale et al (1998) state that, if the team is to be successful, the skills and talents of those

team members must be known and recognised and then matched to the proper task. Without the knowledge of, and faith in, the team members' skills, the act of task delegation becomes a half-hearted effort benefiting neither team member nor team leader (Parsell and Bligh, 1999). Therefore, it is beyond doubt that health care professionals require different knowledge, skills and competencies to function effectively and to deliver the desired outcome in an interprofessional care team.

According to Natale et al (1998), a team cannot succeed unless its members are able to contribute three types of skills and experiences: problem-solving and decision making skills, technical or functional expertise, and interpersonal skills. Similarly, Hornby and Atkins (2000) suggest that relational, organising and assessment skills are the main three collaborative skills required for health care professionals. Relational skills are more about interaction and communication skills whereas organisational skills are required for organising groups, meetings, setting up patient referral systems etc. (Milburn and Walker, 2010). Assessment skills are related to collecting, analysing and reflecting in evidence. Barr (1998) discusses three types of professional competencies – common competencies, interprofessional collaborative competencies and individual competencies for interprofessional working. Engel (1994) highlights the ability to use an understanding of group dynamics, adapting change and participating in change, communication, understanding of how the interaction and productivity of the team as a whole tends to change over time as important competencies for interprofessional working. Hammick et al (2009) describe the following three categories of basic competencies for being an interprofessional practitioner.

'Knowledge

- *Understand the role and working context of other practitioners*

- *Recognise the range of knowledge and skills of all other colleagues*
- *Understand the principles and practice of effective teamwork*

Skills

- *Apply sound verbal and written communication methods*
- *Identify situations where collaboration is helpful or essential*
- *Work collaboratively with service users and carers*
- *Use interprofessional learning in work settings*

Attitudes

- *Appreciate the value of interprofessional working*
- *Acknowledge and respect others' views, values and ideas'*

(Hammick et al, 2009; p.23)

Competencies for interprofessional working have been widely discussed and developed in various reports and literature in Canada. The Interprofessional Education Collaborative (IPEC, 2011) in Canada published an expert report -'*Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel'* in 2011 and highlights values or ethics for interprofessional practice, roles/responsibilities, interprofessional communication and teams and teamwork as main competencies for interprofessional working. Similarly, the Canadian Interprofessional Health Collaborative (CIHC, 2010) published '*A National Interprofessional Competency Framework*' and mentioned the following six competency domains for collaborative practice:

- Interprofessional communication
- Patient/client/family/community centred care

- Role clarification
- Team functioning
- Collaborative leadership
- Interprofessional conflict resolution

These competencies focus on the ability to integrate knowledge, skills, attitudes and values in arriving at clinical judgements rather than relying on the demonstrated behaviours to demonstrate competence (CIHC, 2010). Likewise, the University of British Columbia (2008) in Canada published '*The British Columbia Competency Framework for Interprofessional Collaboration'* and the interprofessional collaboration competencies have been grouped into the following three domains:

- Interprofessional and communication skills
- Patient centred and family focused care
- Collaborative practice
    - Collaborative decision making
    - Roles and responsibilities
    - Team functioning
    - Continuous quality improvement

Miller et al (2001) state that a high level of team knowledge and skills reduces conflict in the message given to the service users about their care plan, diagnosis and management. Health care professionals learning attitude from each other helps to gain knowledge and skills which can be used to deliver health services at times when other colleagues are not around (Hojat et al, 2001). Research in nursing and social care carried out in the UK

(Brown et al, 2000; and Fowler et al, 2000) confirms that community nurses and social workers are positive about sharing of skills, knowledge and identity as generic practitioners because service users are provided with the best service to serve their needs and sharing skills are beneficial to health care professionals.

Drinka and Clark (2000) describe that there are always grey areas of skills and knowledge where health care professionals are skilled and trained in certain fields, but do not have expertise and skills to deal with the problems and issues presented by service users. Engel (1994) argues that health care professionals' competencies gained through academic qualifications, training or experience may diminish unless these skills are used frequently or at least practised intermittently in simulated situations (p.72). In this context, the General Medical Council (2004) suggests that it is the responsibility of health care professionals, managers and leaders to arrange continuing professional and personal development to practise these skills and knowledge in different health care set ups so that they can play their roles and carry out their responsibilities effectively. Furthermore, Duncanis and Golin (1979) state that the roles of team members are generally defined in terms of the particular professional competencies of each team member and the nature of the task to be done.

Hornby and Atkins (2000) define the word 'role' as a part to be fulfilled or carried by a health care professional or group to achieve a shared goal and desired outcome which is essential for interprofessional care and collaboration between health care professionals. Roles can be associated with assigned tasks or behaviour that is expected to be performed by an individual or a team. Sullivan (1998) argues that responsibilities refer to accepting accountability for views expressed, and ultimately for the decisions made. The IPEC (2011) states that understanding of how professional roles and responsibilities

complement each other in health care organisations are an important part of their professional life.

Different scholars and authors have described various team roles for interprofessional working. For instance, Julia and Thompson (1994) describe two kinds of team roles – task and maintenance roles. They further mention that these two roles assumed by the members are characterised to assess the degree to which individual participation either facilitates or hinders the team process; and the concept of role applied to team process provides a way for team members to symbolise the active participation of every other member in a team. Lister (1982) describes roles in the interprofessional team into personal roles, which are based on the personality, socio-economic and cultural factors; and professional roles that are derived from occupational status. Lister further states that professionals may assume other team function roles based on either professional or personal roles, further complicating the analysis of team role function typically seen in team behaviour. Lee and Williams (1994) suggest that the medical doctor performs co-ordinating roles in most of the cases. When performing a particular role, other health care professionals must trust one professional's judgement about whether and how to implement advices from various sources (Robertson, 1992). In the current context of complex health delivery system, no list of health care professionals' roles is comprehensive and no description of their roles can be considered definitive or universal (Reel and Hutchings, 2007). Lister (1982) argues that health care professionals' roles are not static due to constant evolution of roles to make health services more dynamic and seamless and to improve the quality of care.

It is possible that health care professionals' roles and responsibilities overlap (Hornby and Atkins, 2000) as there are so many professionals involved in health care delivery for different health problems or ailments. Overlapping roles and expertise, extended roles

and cross-professional working practice are the factors that may overshadow the clear definition of their roles (Booth and Hewison, 2002). Overlapping and blurred boundaries between professional roles in interprofessional care teams can result in feelings of insecurity and anxiety; and can weaken professional confidence (Barrett and Keeping 2005; Loxley 1997 and Booth and Hewison, 2002).

Hidden roles create misunderstanding of professionals' roles and responsibilities (Baldwin and Daugherty, 2008). It may be due to the lack of clarity of roles or unseen tasks that a health care professional is assigned to carry out. If health care professionals from two different teams or organisations work together, there may be different policies, protocols and practices in place and such practices also create confusion in clarifying the roles of health care professionals (Robertson, 1992). Miller et al (2001) state that the differentiation of roles and the way in which non task based roles can develop are two factors to consider when examining the nature of the role contribution of other health care professionals.

The IPEC (2011) describes that health care team members' roles and responsibilities vary within legal boundaries and actual roles and responsibilities change depending on the specific care situation and sometimes as specified in the terms of references of the job. Reel and Hutchings (2007) argue that roles of health care professionals evolved over time and it may be difficult for some health care professionals when colleagues are taking on some of their roles; however it may be a relief for others as their colleagues are helping them to perform their tasks (p.147). The IPEC (2011) suggests that health care professionals' roles and responsibilities are linked with their competence and skills acquired through formal and informal education and training throughout their professional career and beyond.

From the sources above, it is clear that health care professionals require personal, professional and interprofessional competencies. They learn interprofessional skills and competencies through shared learning. The research findings suggest that the role of health care professionals evolved over time and may overlap with others. Moreover, the literature also suggests that hidden roles may create misunderstanding between health care professionals. The roles of health care professionals also vary within the legal and organisational boundaries.

As Fagin (1992) claims, collaborative practice in health care organisations is no longer a choice and every member of a health care team plays a vital role to achieve shared goals and optimal desired outcomes. Hammick et al (2009) argue that health care professionals understand the values, roles and skills of others in a health care team so that everyone can contribute in a harmonised way. Furthermore, effective interprofessional care depends on effective interaction, communication and collaboration within the team, along with sufficient resources and support from the management (Fitzsimmons and White, 1997).

2.5 Communication and Interaction between Health Care Professionals

Communication is the key for all health care professionals to function in an effective way, and sound relationships between health care professionals are vital for good communication amongst them (Hornby and Atkins, 2000). Delva et al (2008) suggest that effective teamwork relied on team communication based on respect and feelings of comfort with other team members. Harbaugh (1994) describes that the word interprofessional implies interaction and a commitment to interaction and good communication is the key to successful teamwork. Communication does not only include content, but it also considers relationships (Way et al, 2000). Communication involves the ability to communicate effectively with other health care professionals and service users in a collaborative, authentic and responsible way (Drinka and Clark, 2000).

Larson (1999) carried out a study on the impact of physician-nurse interaction on patient care and confirmed that failure to interact and co-ordinate between physician-nurse in a positive way results in an unhealthy work environment and poor patient outcomes. The extent to which various health care professionals communicate and interact together can affect the quality of the health services that they provide (Mills et al, 2008). If there are problems in how health care professionals communicate and interact with each other, then problems in patient care can occur (Zwarenstein et al, 2009). Poor interprofessional communication between health care professionals has been linked to decreased quality of patient care and increased numbers of medical errors (Verhovsek et al, 2010). Delva et al (2008) highlight that communication barriers with physicians were thought to be due to conflicts in schedules and roles, and for nurses, the building layout was deemed responsible for lack of interaction between different teams. Scarnati (2001) suggests that an important factor discouraging teamwork is ineffective organisational communication. In research regarding interprofessional working, Street and Blackford (2001) conclude that ineffective communication jeopardises continuity of care.

Studies in intensive care units and operating theatres in Canada by Lingard et al (2004, 2002) documented the impact of poor communication on safety and work processes. Clinical incidents in health care set up occur as a result of no communication or breakdown of communication between health care professionals and patients or amongst health care professionals (Jones and Jones, 2011). Effective communication between health care professionals and patients reduces clinical incidences, misunderstanding and errors, and enables health care professionals to be more readily aligned to the departmental and organisational vision (Mills et al, 2008; Verhorsek et al, 2010; CHSRF, 2006). This gives an opportunity for health care professionals to work together for the satisfaction of the staff and service users, for improving the quality of care and supporting

a healthy working culture. Effective communication enables health care professionals to be more aware of the internal and external issues such as service users' dissatisfaction, discontent, pressures on health care professionals, and promotes the opportunity for effective, efficient and flexible management of health services (Hammick et al, 2009).

According to Larson (1999), the way a physician and a nurse interact has an impact on patient care and perceptions of the physicians and the nurses vary in accordance to which collaboration and joint decision making are valued due to differences in historical origins of professions, disparities between physician and nurses with regard to socioeconomic status, gender, education and socialisation. An ethnographic study carried out in Canada (Reeves et al, 2009), gathered data from a wide range of health care professions to explore the nature of interprofessional interactions within general and internal medicine settings. The study by Reeves et al indicated that both formal and informal interprofessional interactions between physicians and other health professionals were terse, consisting of unidirectional comments from physicians to other health professionals. In contrast, interactions involving nurses, therapists and other professionals as well as intra-professional exchanges were different - richer and lengthier, and consisted of negotiations which related to both clinical as well as social content (Reeves et al, 2009). Bennett-Emslie and Mclntosh (1995) carried out a research in the United Kingdom to identify and assess the participants' perceptions that promotes collaboration in primary care. They interviewed 70 health care professionals from 14 general practices. The findings suggest that the participants identified the frequency of team meetings as the most important factor that promote interprofessional working.

Perakyla (1997) argues that the effectiveness of health care professionals depends upon the communication and interaction among members and when communication is not clear and disrupted, it is difficult to gain team effectiveness. According to Kipp & Kipp (2000),

authenticity is fundamental in this regard – a willingness to speak one's mind. Therefore, communication is vital in achieving a team's goals and objectives. Miller et al (2001) state that many team-minded health care professionals believed that detailed communication enhance their practice and benefit the client. The CIHC (2010) states that effective communication between health care professionals is dependent on the ability of the health care teams and their members to deal with conflicting viewpoints and reach reasonable compromises.

Julia & Thompson (1994) highlight that the nature of interprofessional communication is complex and the reader is referred to other references for an in-depth discussion. Julia and Thompson describe that interprofessional team communication does not differ from interpersonal communication on other teams, however, the degree to which some professional team members are more skilful and more alert to the communication process in team function. Hall (2005) agrees and states that the team is bound by the rules of communication that lead to effective interpersonal communication.

According to Kane (1983), the existence of fragmented team structure hinders communication and interaction, the communication process is part of an overall organisational system and occurs mostly in a defined way within the organisational context and norms. Miller et al (2001) argue that one of the issues of interprofessional care teams is the use of separate communication systems by the different professions within the team. The development of joint communication systems is considered as a fundamental aspect of good practice in an interprofessional care team (Lingard et al, 2002). Using a joint note keeping document is an example of the joint communication system which consists of a record of all aspects of assessment, care planning and management of service users.

The IPEC (2011) states that professional hierarchies create demographic and professional differences and also create dysfunctional communication patterns which works as a barrier to effective interprofessional teamwork. Moreover, there are research findings (WHO, 2005; Borrill and West, 2002; EIPC, 2005; Oandasan et al, 2006) which suggest that such communication pattern places responsibility on all health care team members to speak up in a firm but respectful way when they have concerns about the quality or safety of care. However, such form of communication keeps health care professionals from sharing their skills and knowledge across professional boundaries (Fitzsimmons and White, 1997).

The research findings mentioned earlier show that effective communication and interaction between health care professionals improve clinical outcomes and there is an impact of poor communication on safety and work process. The effectiveness of team collaboration and performances of health care professionals depends on the way they communicate and interact. Moreover, sharing information between health care professionals and teams is an important aspect of interprofessional working. According to Harbaugh (1997), knowing that to send and receive timely, confidently, appropriately constructive feedback and use of appropriate means of communication helps health care professionals improve interprofessional working and sound decision making by enhancing their capability and strengthening interprofessional care team leadership. The following section 2.6 describes the literature available on different aspects of leadership and decision making in interprofessional working.

2.6 Human Factors in Health Care

This section covers literature on human factors and establishes its relationship with interprofessional working in health care. It also introduces human factors and discusses

the importance of human factors in health care and the various ways of mitigating risks of human factors errors in the delivery of health services.

The term ‘human factors’ is widely discussed and researched in the field of patient safety and health and safety. The Health and Safety Executives (1999) defines human factors as ‘environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety’. According to the Health and Safety executives, a simple way to view human factors is to think about three aspects: the job, the individual and the organisation and how they impact on people’s health and safety related behaviour. The Food and Drug Administration (2009) defines human factors as ‘the study of how people use technology. It involves the interaction of human abilities, expectations, and limitations, with work environments and system design’. This definition links the use of technology in health care with human factors. According to the Human Factors and Ergonomics Society (2015) ‘human factors is concerned with the application of what we know about people, their abilities, characteristics, and limitations to the design of equipment they use, environments in which they function, and jobs they perform’. It can be noted from the definitions above that human factors is a broad term which is used in many contexts that includes human behaviours, skills, technology, design and performance. Its main objective is to minimise the risk of human factors errors and to improve performance in health services.

Human skills are vital for health care professionals to effectively communicate, interact, manage and lead team members. The foundation of team performance in health care organisations is interpersonal skills, which is largely affected by human factors. Health care professionals are humans; hence their attitudes, knowledge, skills, behaviours and values have great impact on delivery of health services. Interpersonal understanding and

team building approach starts from the nature of people, their relationship with each other and therefore, their relationship to work (Rawson, 1994). The lack of attention to training in human factors contributes to the lack of situational awareness, poor communication and teamwork failures (Patient Safety First, 2010). According to Gurses et al (2012), the main objective of studying human factors in health care organisations is to maximise performance and to promote health and safety, comfort and quality in the working lives of health care professionals. Previous literature shows that human factors are major elements affecting patient safety and adverse events in health care (Perrow, 1984; Institute of Medicine, 2000); which is mostly related to medication errors, working hours and conditions such as tiredness, lengthy working hours and high workload (Institute of Medicine, 2006; Ulmer et al, 2008).

Vincent et al (1998) carried out research on human factors in relation to teamwork in health care and asserted that four factors – communication, supervision, seeking help and team structures are the major factors that may influence clinical outcomes in health care. Reduction of patient safety incidents by improved communication and interprofessional working has been reported in Canada by Oandasan et al (2005). Quality of interaction and communication among health care professionals and between service users may also influence the decision making process in interprofessional care (Reeves et al, 2009). A study in intensive care in an acute hospital confirms ineffective or poor interprofessional working is linked to poor patient care outcomes (Baggs et al, 1999). Similarly, previous studies in patient safety in health care organisations confirm that patient safety culture has been correlated to health care professionals and patient safety incidents (Hofmann & Mark, 2006; Zohar et al, 2007). Other studies have confirmed that human factors errors are the major cause of critical incidents related to patient safety in the clinical care environment where patient monitoring takes place in health care settings, which

contributes approximately 87% of all such incidents (Walsh and Beatty, 2002). Moreover, Feyer and Williamson (1998) assert that up to 90% of all workplace accidents have human error as a cause. Human factors encompass various aspects that can influence people, their behaviour at work, teamwork, interprofessional working and the delivery of safe health care. Interprofessional care involves working together to achieve something beyond the capabilities of health care professionals working alone and many of the jobs in health care organisations are completed through interprofessional team collaboration. Therefore, human factors and interprofessional working in health care are associated with each other in terms of the delivery of safe and improved health care to service users.

The Health and Safety Executives (2009) states proper investigation of incidents caused by human factors errors helps to find contributing factors and the root causes of such failures and to prevent the chance of reoccurrence. Another way of mitigating risks of human factors errors and improving the health care professionals' physical and mental wellbeing is '*ergonomic changes to the task and the working environment*' (Health and Safety Executives, 2007, p.8). Similarly, Walsh and Beatty (2002) assert that human factors errors can be reduced by designing cognitively ergonomic equipment in health care.

In summary, human factors assesses how health care professionals interact with their environment, facilities and other professionals or people and the delivery of health service depends on the way health care professionals work together. The successful interprofessional working also depends on how health care organisations and professionals prevent human factors errors as discussed above. The focus on human factors to improve the quality of care and patient safety and for the successful delivery of

interprofessional working is an important aspect considered by health care professionals, health care organisations and policy makers.

2.7 Decision Making and Leadership in Interprofessional Working

Decision making is a systematic process of collecting information, analysing the case and deciding the appropriate course of action for the best interest of service users. According to Hornby and Atkins (2000), decision making in interprofessional care is a process to discuss the issue collaboratively and to come to the conclusion jointly to offer the best options of care amongst all alternatives. Colyer (2012) describes that professional decision making is a complex process and it involves the interaction of various things such as knowledge, experience, expertise, values and theoretical perspectives. According to Bope and Jost (1994), the successful interprofessional care team makes decisions by consensus, with deference to the opinions of professionals with the most relevant professional experience. The result of discussion, assessment and examination of the situation from several perspectives between health care professionals, yield a decision that is more appropriate, relevant, comprehensive and creative than the decision one member of the team might have reached alone (Bope and Jost, 1994). In a practical sense, decision making in collaborative practice is collective responsibility based on evidence in which mutual trust, respect and clinical needs are the considerations (WHO, 2010).

Hawley (2007) describes three stages of decision making in interprofessional care context – assessment, systematic analysis and critical analysis and proposes a decision making framework for interprofessional care and collaborative practice. Empirical research suggests that service users who are actively involved in decision making about their health care have significantly improved outcomes (England and Evans, 1992; Anderson et al, 1995). Another research in clinical decision making concludes that there are advantages of shared decision making, sharing knowledge and authority in clinical set

ups (Coulter, 1997). McMillian et al (2003) argue that doctors' approaches to shared decision making benefit service users, but have some limitations of sharing skills and knowledge.

According to the WHO (2010), interprofessional collaboration is effective when there are opportunities for shared decision making and routine team meetings. This may facilitate health care professionals to decide on shared goals for the care plan and management of service users. It may also help to balance their individual and shared tasks and to negotiate shared resources for effective delivery of health care. Appropriate information systems and processes, effective communication strategies, strong conflict resolution policies and regular communication, discussion and dialogue among health care professionals and team members play an important role for shared decision making and in establishing a good working culture (WHO, 2010).

Health care professionals interact with service users to make decisions about the care plans, the treatment and management and they have potential power to perform good or harm during the service delivery process (Hawley, 2007). Norman (1985) argues that it is very important that health care professionals use their knowledge, skills, expertise and professional judgement to decide the best option in the interest of service users in a collaborative way. Different professional teams or individuals may have their own priorities, thoughts and alternative views for treatment options. It may create debate or conflict in interprofessional care and collaborative practice to decide the best course of action for the service users in health care (Colyer, 2012). Coulter (1997) argues that in decision making process, the choice over various treatment or care alternatives and the weight given to various aspects of health care depends upon the health care professionals' culture and autonomy. Getting health care professionals to take ownership of decisions, so that they are implemented, is one of the most important tasks of health care team

members (Wagner, 2004). Decisions also need to be owned by the organisational and professional hierarchies; and the team leader, and they need to work upwards and sideways as well as downwards (Gorman, 1998).

The team leader is the one who drives, motivates and inspires the team members to achieve the common goal and desired outcome and the interprofessional team's performance is not easily achieved without the leader (Zaccaro et al, 2009). According to Julia and Thompson (1994), leadership that takes place in an interprofessional team is another element to effective team functioning and leadership functions are actions and behaviours that any team member may carry out, but the leader generally takes responsibility for them. Engel (1994) agrees and mentions that the leader plays a vital role in facilitating the interprofessional team through its various development stages in order to achieve the desired outcome by planning, controlling, evaluation, collaboration, intervention etc. Willumsen (2006) argues that the role of leadership in interprofessional care and collaborative practice is performed usually by the participants in order to drive the interprofessional working practice agenda forward. Drinka and Clark (2000) state that if interprofessional care teams are to thrive, they must become lean, capable and refined units for health care delivery. The team leader has the overall responsibility for achieving the desired outcome and shared goals whereas an individual member of the team and the organisation also take the shared responsibility to achieve this (Tourangeau, 2010).

Different health care professionals could be in charge or a leader of a health care team depending upon the nature, composition and requirements of the team and medical professionals may play vital roles of leadership most of the time. Kane (1983) studied leadership in 138 teams and found that physicians (doctors) led 65.2 percent of the teams, social workers led 9.4 percent of the teams, educators led 8 percent of the teams, managers or administrators led 7.2 percent of the teams, nurses led 2.2 percent of the

teams and psychologists led 1.4 percent of the teams (quoted in Bope and Jost, 1994). Recent research in the leadership in health care also supports this finding. Most clinical teams and professional groups in health care are led by senior clinicians (Fagin, 1992; Hammeman, 1995; McWilliam et al, 2003; Richardson and Storr, 2010). A health care professional with a lot of experience with a clinical specialty related to problems of service users can best lead and manage interprofessional care team (Kaini, 2015). In terms of experience, expertise and seniority; senior clinicians or professional leaders have important roles to encourage and motivate fellow colleagues and team members so that an effective interprofessional working practice can be achieved (The Kings Fund, 2011). They can influence team members through being a role model, professional opinions, organisational positions they hold and the organisational decision they made (Miller et al, 2001). Senior professional leaders are required to balance their roles as an expert of their profession with their organisational roles in the delivery of effective health service to service users (Hoffman et al, 2007). The Health Force Ontario (2010) suggests that the leader of an interprofessional care team needs to have change management abilities and leadership skills, and be capable when it comes to embedding interprofessional care principles into the planning processes for health care delivery and developing interprofessional care as a tool to address the needs of the health care system (p.24).

Willumsen (2006) conducted research on the leadership in interprofessional care in a child care setting in Norway and concluded that health care managers exercised leadership power for self governance and co-governance and used strategies to influence different aspects of governance. Willumsen further states that the experiences of leadership in interprofessional care comprised three categories – external responsibility (establishing communication channels and providing resources), sustaining communication (encouraging interaction processes) and internal responsibility (relating

to formal framework and dealing with everyday activities). Within the interprofessional collaborative care, the concept of leadership is a shared leadership and health care professionals support the choice of leader depending on the context of the situation (CIHC, 2010).

Different health care professionals and team members may have different styles, background, interests and roles (Fagin, 1992; Zaccaro et al, 2009; Sobero et al, 2008; Schein, 1985; D'Amour et al, 2004). Koerner and Bunkers (1992) argue that all team members do not want the same type of leadership as some may want their leader more involved, they may want more directions from their leaders, while others may want to have minimal involvement. Reel and Hutchings (2007) argue that leadership becomes ineffective when the leader provides the same style to all members. Therefore, a good leader needs to be dynamic, charismatic and effective so that the leader can satisfy the different needs of the different team members.

The leaders of interprofessional care teams are guided by policies, protocols, guidance and standards (Willumsen, 2006) and these documents play important roles in defining the roles and tasks of team members and health care leaders; and achieving common goals and optimal desired outcome. The Health Force Ontario (2005) claims that the health care leaders and team members can avoid confusion, duplication and frustration and can contribute to a collaborative practice by following procedural documents. Health care leaders also play the role of ambassador and diplomat (Engel, 1994) as they need to satisfy external partners and internal stakeholders; and make sure that the environment in which the team is to function is supportive and enabling.

Hawley (2007) suggests that leaders of the interprofessional care team, like all leaders, have to balance the demands of the health care organisation with the team dynamics and the needs of team members. Health care professionals find out if the sense of track and

power that leadership should provide is missing (Hornby and Atkins, 2000). There are many things that can make leading interprofessional teams more challenging than any other teams. One of the complex and challenging issues is the multiple lines of accountability (Coyler, 2012) that health care professionals can have. The lines of professional accountabilities and responsibilities are not often as clear as they appear on the organisational structures and charts (Gorman, 1998).

In summary, the literature suggests that decision making in health care teams is mostly done by consensus and health care professionals take the ownership of decisions made by them. Moreover, the literature also confirms that service users' involvement in decision making improves clinical and health care outcomes. Colyer (2012) states that decision making is a key characteristic of professional autonomy and health care team leaders need to make sure that decision making process is open and transparent for the effective interprofessional care and collaborative practice. Health care professionals have to make sure that clinical decisions are made for the best interest of service users (Department of Health, 2004). One of the tasks of the leader of interprofessional care teams is to work for professional identity and to set boundaries for professional autonomy (Rafferty et al, 2001).

It is beyond doubt that health care leaders are equipped with a set of skills and they play important roles in the delivery of interprofessional care, even though different groups of health care professionals have different leadership styles. The literature also suggests that most of the interprofessional care teams are led by medical professionals. Leaders of interprofessional care teams have a great impact on decision making process and they also play vital roles in the management and delivery of health services. Moreover, the literature confirms that shared leadership is a common practice in interprofessional teams.

However, it is observed that multiple lines of accountability or leadership in health care settings and teams is one of the challenging aspects of interprofessional working.

2.8 Interprofessional Identity, Autonomy and Boundary

Individuals are thought to associate themselves with groups they have an affinity with and thus identity is '*the individual's knowledge that he/she belongs to certain social groups together with some emotional and value significance to him/her of this group membership'* (Tajfal, 1972, p. 292). Individuals define themselves by joining groups that have meaning or importance to them and where there is a value match. Wackerhausen (2009) defines professional identity as a combination of what the public think about the profession and the profession's official recognition. Professional identity is a learning process which requires the acquisition of particular knowledge and skills that are essential for a professional role and the development of new beliefs, working culture, values and attitudes (Hall, 1987; McGowen & Hart, 1990; Watts, 1987). According to Hornby and Atkins (2000), professional identity is linked with individual identity and it is associated with working roles. Hawley (2007) argues that when a health care professional belongs to a professional group, the professional identity of an individual is viewed as a subset of the group identity. Then the individual could also be a member of a different working team, where his identity could be different from professional identity.

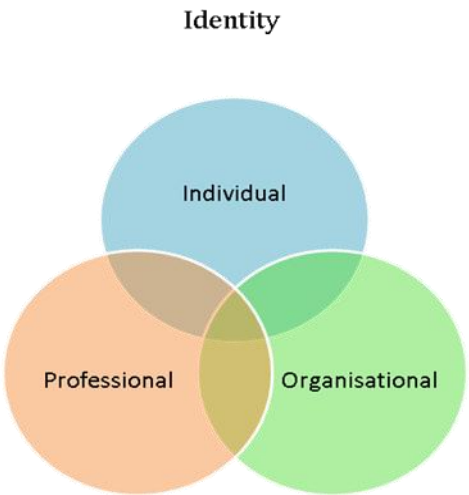
Health care professionals require a strong, cohesive and satisfying professional image with which practitioners can identify (Pellatt, 2007). Health care professionals have a set of expectations on how each of the members should behave as the group works to achieve the goals. According to Duncanis and Golin (1979) these expectations may lead to their unique identity and may develop the following four identities or images:

- A personal and professional self-image

- Expectations of his own profession in that setting
- An understanding of the skills and responsibilities of his or her colleagues, and
- A perception of his or her colleagues or him or her.

Individual identity and professional identity are two different things, but self-image, individual identity and self-esteem are linked to professional identity (Hornby and Atkins, 2000). Therefore, individual identity supplements to form a solid image of professional identity. According to Wackerhausen (2009), professional identity is shaped by qualification, experience, expertise and social factors whereas personal identity is formed by various personal sources such as physical, psychological and emotional factors. According to Barrett and Keeping (2005), health care professionals develop a sense of identity from their professional roles and they become physically attached to their professional group through the process of professional identity and becoming dependent on its existence. Stapleton (1998) states that a combination of professional and personal identity boosts the confidence of health care professionals and enables them to emphasise their perspectives and challenge the viewpoint of other professionals.

Figure 1: Individual, Professional and Organisational Identity



Brott & Kajs (2001) argue that professional identity is formed at two levels when people join a new organisation - structural and attitudinal. Hornby and Atkins (2000) suggest that professional aims, attitudes, values, skills, knowledge and authority are essential elements of the role which is linked to professional identity.

Lee and Williams (1994) argue that unique professional heritage of a medical doctor affects their relationships to an interprofessional care team. Farrell et al (2001) conclude that physicians are dominant in a health care team and other health care professionals are seen as less active and less task oriented, but more sociable and warm. Farrell et al also argue that the more education the team members have, the more prominent and task oriented they are. Other health care professionals may also have their unique professional identity and character that may affect their interprofessional working practice.

According to Biggs (1997), the success of interprofessional care depends upon the right balance between the maintenance of separate identities, merging to fulfil a shared objective and the resolution of possibly conflicting loyalties. The success of an interprofessional care team depends on the appreciation of differences, interdependence and shared goals. Identity of health care professionals is also influenced by a psychological and social environment (Hertzberg, 1993).

The interprofessional care team can include different professionals from different cultures working together for a shared goal. Miller et al (2001) suggest that health care professionals' loyalty would be to their own professional group and they form a strong professional identity based on their knowledge, skills, loyalty and cultures. Professional identity also carries status and power through organisational and societal recognition. In this sense, professional culture also reflects the power and status assigned to it in the ways that it develops. Public trust and professional personhood are important components of professional identity (IPEC, 2011).

Reel and Hutchings (2007) suggest that interprofessional working may seem to contradict with contemporary practices in health care, that of being an autonomous and independent practitioner. However, Rafferty et al (2001) argue that an interprofessional care team is an ideal place for making interdependent and complex decisions in a holistic approach to health care. It may bring many dependent and autonomous health care professionals together so that they can contribute by comparing and contrasting their knowledge, skills and expertise with other members of the health care team. Health care professionals exercise their professional judgement and they tend to be autonomous by their nature of work which gives them a very high degree of control of their own clinical practices (Latella, 2000). Bayles (1981) agrees and mentions that professionals are autonomous as they can make independent judgments about their work. Hoogland and Jochemsen (2000) state that professional autonomy is often described as a claim of professionals that they have to serve primarily their own interests...this professional autonomy can only be maintained if members of the profession subject their activities and decisions to a critical evaluation by other members of the profession.

Crozier (2003) states that there is a crisis of professional identity among midwives with a fear that their professional autonomy is at stake. Rafferty et al *(*2001) confirm that teamwork and autonomy are significantly correlated with each other and nurses with higher levels of teamwork also have higher levels of autonomy and are more involved in decision making. Dent and Burtney (1996) mention that medical professionals have been able to join hands in a collaborative way with the government compared to the other professions. This may be due to the reliance of the government on the medical profession in the organisation and control of health care delivery. Freidson (1970a), in his book *Professional Dominance,* mentions various components of professional dominance such

as autonomy over work, control over the work of others in one's domain, cultural beliefs and deference; and institutional power.

Duncanis and Golin (1979) argue that there are differences between various health care professionals in how much professional autonomy is exercised and who decides how much autonomy is allowed. The level of autonomy is not the same throughout their career and professional autonomy changes along with their skills, training, expertise, competence and experiences as they move further up their career ladder and hierarchy (Wade, 1999). The trainee health care professional is expected to demonstrate the responsibility and accountability of a professional, but in a different manner in comparison with the registered or licensed professionals (Hammick et al, 2009). They are expected to engage proactively in interaction and communication with other health care professionals.

The Health Professions Council (2008) argues that health care professionals are autonomous if they can make decisions based on their judgement. The Health Professional Council describes that as all registered health care professionals are autonomous and accountable, they need to make informed and reasonable decisions about their practice to make sure that they meet the standards that are relevant to their practice. Freidson (1986) argues that professional employees are autonomous in one sense and they are not autonomous in the other sense. Health care professionals have privileges to practise their discretion, but also have to be bound by the organisational norms and protocols. Coyler (2012) claims that the professional autonomy of a health care professional group is associated to a certain scope of practice, the limits of which are contestable as boundaries are blurred (p.188). According to Sullivan (1998), professional autonomy ensures that health care professionals are empowered to deliver health services within their respective profession and practice. Way et al (2000) state that professional

autonomy involves the authority of the individual health care professional to independently make decisions and carry out the treatment plan; it is not contrary to collaboration and serves as a complement to shared work.

However, there are different views about professional autonomy which contradict to the statements above and research findings. For example, Evans (1992) and Pike et al (1993) state that collaboration requires interdependence rather than autonomy as health care professionals depend on one another. Colyer (2012) suggests that collaborative practice may fail if health care professionals and team members do not recognise the importance of professional autonomy and do not acknowledge autonomy of others, expressed in respect and trust. Therefore, it is important to consider the basis in which respect for the autonomy of the other professional groups is a valid demand (Colyer, 2012).

Brown et al (2000) suggest that health care professionals must balance their professional autonomy and boundaries with their involvement in interprofessional care team. Odegard (2005) highlights that interprofessional working is affected by factors at the individual as well as the group and organisational levels. Pete et al (2010) claim that partnerships are complex arrangements that present several challenges to the professionals and managers seeking to coordinate and deliver health and social care across traditional professional and organisational boundaries.

Teamwork requires all individuals to embrace the concept of interdependence (Scarnati, 2001). Professional boundaries can be marked within the concept of interdependence so that all health care professionals can practise their professions for the best interest of service users. However, Sebas (1994) argues that collaborative care practices occur between different health care professionals such as doctors, nurses and allied health care professionals but in a way defined by their respective areas of expertise and practice. To support this, Pellatt (2007) states that all professionals have their own unique images that

are considered as *'a basic requirement to separate themselves from the rest of the other professionals*' (p.166). Two studies by Hughes (1998) and Allen (1997) suggest that the communication and interaction between health care professionals such as the doctors and the nursing staff are changing and the conventional and professional boundaries between health care professionals are breaking down.

Henderson (2004) argues that the professional boundaries between health care professionals who are in any kind of working relationship with each other are often defined by the roles they play. Some functions carried out by health care professional are common and are shared by many different groups. There are mainly two opposite views of professional boundaries between health care professionals. In one way, there are no clear boundaries between health care professionals as there are many grey and overlapping areas which make their boundaries unclear (Scarnati, 2001). Contrary to that, a professional boundary is a clear demarcation line which is like a concrete wall between two or more professions in terms of their expertise, knowledge, skills, roles and responsibilities (Pellatt, 2007; Sebas, 1994).

Traditional boundaries between health care professionals and their territory are also shifting in many cases (Reel and Hutchings, 2007). Hornby and Atkins (2000) describe that professional differences lie in their functions, methods, skills and responsibilities; but there are overlapping areas of shared professional territory. A shadow area of professional boundaries may bring threat to professional identity (Wackerhausen, 2009). Leathard (1994) suggests that a careful examination and assessment of professional roles and role boundaries in different professional groups and settings may enable health care professionals to recognise the periphery of professional groups. D'Amour and Oandasan (2005) argue that structures such as those found in health care set up and professional systems have great impact on the development and regulation of professional boundaries.

However, social values and pressures can drive innovative ways of working and can compel health care professionals to be more open to new orientations and approaches to clinical practice (D'Amour and Oandasan, 2005).

From the review of literature, it can be concluded that professional identity is shaped by the qualifications, experience, roles and social factor of a health care professional. Medical professionals enjoy more power and recognition in an interprofessional care team and they are more dominant. It shows that the more education and influence health care professionals have, the more prominent they are in health care teams. Furthermore, it is clear that health care professionals tend to be autonomous by their nature of work. Literature suggests that professional boundaries in health care teams are defined by their respective areas of expertise and there are large overlapping areas of shared professional territories between health care professionals. Moreover, the way health care professionals work together within and outside the professional boundary for interprofessional working may have consequences on the clinical outcome and delivery of health care which is discussed in detail in the next section.

2.9 Impact of Interprofessional Working

Health services are designed to provide the best possible care to service users and families, to improve the quality of life, to alleviate health issues and to improve health conditions (Kaini, 2005a). Effective health care cannot be achieved in isolation. The health care delivery system is based on a sequence of co-ordinated activities of professionals from various disciplines. According to Wanger (2004), it requires synchronised and rigorous efforts from all health care professionals and individuals and also an appropriate care delivery system.

The main objective of interprofessional working is to bring a broader scope of knowledge, skill and expertise in order to improve the quality of care and clinical outcomes related to the health problems and issues of service users (Bope and Jost, 1994). In this context, the main question of interprofessional working is whether interprofessional care benefits patients, service users, their families, health care professionals and the health system. Interprofessional working comes into practice to ensure that health care professionals can complete a care task or combination of tasks that they could not achieve effectively on their own (Reeves et al, 2010). According to Schmitt (2001), the impact of interprofessional working should be assessed across the range of problems for which the health care team has been formed and operated.

Health care professionals in an interprofessional care team use various means in order to discuss and collaboratively set treatment goals for service users (Reeves et al, 2010). According to Xyrishis and Iowton (2008), health care professionals jointly carry out the treatment plans and there is a high degree of interaction, communication, co-ordination and cooperation among health care professionals. The outcome of this approach is that health care professionals gain a number of skills across multiple disciplines to achieve the desired outcome, to improve service users' experience and health care professionals' work satisfaction (Korner, 2010).

There is very little controversy about the importance of interprofessional working to service users, health care professionals, health system and health care organisations. For instance, D'Amour and Oandasan (2005) confirm that interprofessional working has a four-fold impact that takes into consideration patient, professional, organisational and system outcomes. Similarly, Petri (2010) highlights positive consequences of interprofessional working on three aspects – the service users, the organisation or system and the health care professionals. Enhancement of patient care and improved quality of

care or outcomes for service users, cost containment and improved productivity in health care organisations and enhanced job or professional satisfaction and retention of personnel are the potential consequences found to impact the patient, the organisation or system and the health care professionals.

The Health Professions Regulatory Network (2008) highlights the following outcomes associated with collaborative practice for service users, health care professionals and health care organisations:

'Outcomes of collaborative practice for service users/patients:

- *improved patient satisfaction*
- *improved patient transfer and discharge decisions*
- *improved patient care and outcomes*
- *decreased risk-adjusted length of stay for patients*
- *reduced medication errors*

Outcomes of collaborative practice for health care professionals

- *improved job satisfaction*
- *decreased job associated stress*
- *lower nurse turnover rates*
- *improved communication among caregivers*
- *improved efficiency*
- *improved understanding of roles*

Outcomes of collaborative practice for health care organisations

- *decreased costs*
- *improved efficiency of health care providers'*

(The Health Professions Regulatory Network, 2008; p.3)

Leathard (2003) confirms the following benefits of the interprofessional working which emerged throughout the 1990s and into the twenty-first century:

- '*Recognition of interprofessional care by sharing knowledge and expertise*
- *More satisfying work environment as health care professionals share knowledge and support each other*
- *Integrated and comprehensive services as a response to the growth in the complexity of health and social services'*

(Leathard, 2003, p.9)

Miller et al (2001) state that interprofessional working is regarded as a vital factor to improve the quality of patient care and it has to be supported by an appropriate team structure, process and system. Mickan et al (2010) carried out a case study in ten countries on behalf of the 'WHO Study Group on Interprofessional Education and Collaborative Practice' and highlighted the importance of collaborative practice *'to help enable health systems worldwide to provide safe, timely and quality services with limited human and financial resources*.' (p.493).

Paul and Peterson (2001) conducted a study among occupational therapists to assess their perceived issues and practices related to interprofessional working. They argue that interprofessional education, practice and research can have economic benefits and effective clinical outcomes, which may be viable means for improving health care delivery. However, this study lacks evidence of improved outcomes on any specific

clinical or other fields. Belza (2007) suggests that everyone can benefit when working effectively in an interprofessional team by joining forces, establishing goals and creating plans. Belza further argues that team members can benefit from each other's skills; and they can build synergy and avoid duplication of efforts when they collaborate with each other. Petri (2010) confirms that consequences of interdisciplinary collaboration are beneficial to service users, health care systems and health care organisations by using problem focused processes, sharing and working together.

According to Turby and Turby (2012), synergy is one of the most beneficial outcomes of teamwork and interprofessional care. Synergy is defined as the whole is greater than the sum of the parts. This concept is applied in those health care services where resources are limited and responsibility is shared between health care professionals (Kelher; 1997). Interprofessional working has advantages in some clinical procedures as jobs do not need to be repeated by each professional (Henneman, 1995). The Health Force Ontario (2010) states the following benefits of interprofessional care in its report '*Implementing Interprofessional Care in Ontario: Final Report of the Interprofessional Care Strategic Implementation Committee'*:

- *'increased access to health care*
- *improved outcomes for people with chronic diseases*
- *decreased tension and conflict among caregivers*
- *better use of clinical resources*
- *easier recruitment of caregivers*
- *lower rates of staff turnover'*

(Health Force Ontario, 2010, p.v)

The Canadian Health Services Research Foundation (CHSRF) conducted research on teamwork in health care and published a report *'Teamwork in Health care: Promoting Effective Teamwork in Health care in Canada'* in 2006. It confirms the following outcomes and benefits of interprofessional working and teamwork:

- Health care professionals working in an interprofessional care team and in a collaborative manner are more satisfied and have a more positive experience, when compared to health care professionals working in an un-interprofessional model.
- Health care professionals who experience working in an interprofessional collaborative manner develop a positive perception of working collaboratively with other professionals.
- Health care professionals who work in an interprofessional collaborative manner develop enhanced knowledge and skills.
- Interprofessional collaborative models can provide a broader range of services, more efficient resource utilisation, better access to services, shorter wait times, better coordination of care and more comprehensive care.
- Service users expressed more satisfaction and identified a more positive experience with interprofessional collaborative.
- Service users receiving services from health care professionals through an interprofessional collaborative approach develop enhanced self-care and health condition knowledge and skills.
- Effective utilisation of health resources.

Increasing levels of complexity of knowledge and skills required to provide care for different types of service users in health and social care led to an increase in specialisation of health care disciplines and decreased interdisciplinary exchange (Verhovsek et al, 2010). According to Dow and Evans (2005), the advantages of working interprofessional care team when patient problems are complex include:

- a wider range of expertise is available to inform problem solving
- the burden of difficult challenges can be shared
- tasks can be divided between those involved, and team members can support and motivate one another.

Dow and Evans further argue that the primary aim of interprofessional working is a better outcome for service users, but there are also the benefits of improved support and shared decision making for the professional involved in what is often difficult and demanding work. Crowley and Wollner (1987) add the following benefits of implementing collaborative practice:

- '*Improvements in communication, trust and respect*
- *Increased understanding of each other's professional cultures and responsibilities*
- *Greater consideration of each other's time and effort*
- *A more collegial atmosphere which leads to improved job satisfaction*
- *Joint working for the joint development of consistent policies and standards of practice*
- *Implementation of changes before they are induced by crises*
- *Consideration of all team members' opinions and suggestions*

- *Reduced tension at all levels within the health care set ups'*

(Crowley and Wollner; 1987; pp. 59-63)

Many work environments suffer from a lack of support for collaborative, team-based care, but improved collaboration and teamwork through interprofessional care can assist caregivers to work more effectively by helping to manage increasing workloads, reduce wait times and reduce patients' likelihood of suffering adverse reactions as a result of the care they receive (CHSRF, 2006). Research on human resource practices in NHS hospitals establishes a link between working practice and clinical outcome and concludes that interprofessional working and appraisal systems led to improved service users' care; and staff training is linked to patient mortality (West, 2002). Latella (2000) identifies benefits of interprofessional working in rehabilitation to service users, health care professionals and the overall health system.

Health care organisations benefit from interprofessional working, since professionals work more efficiently, share expertise and trust each other (West et al, 1998). Similarly, Haire (2010) highlights that many health care organisations have adopted interprofessional working in the interest of efficiency and effectiveness of the health services and for utilising available resources in a better way. D'Amour et al (2004) also suggest the effects of interprofessional working on the overall health care system are trust between health care professionals, reduced cost, efficient services, improved job satisfaction and greater responsiveness.

The impact of interprofessional working has been assessed in many health care professionals. The medical literature on collaboration between registered nurses and medical professionals is extensive. Barrere and Ellis (2002) confirm that interprofessional working between doctors and nurses was a fundamental factor in positive patient

outcomes regardless of the severity of a patient's condition. O'Brien-Pallas et al (2005) have also gathered evidence of the positive outcomes of nurse-doctor collaboration in Canada. Zwarenstein and Bryant (2000) carried out research to assess the effects of interventions designed to improve nurse-doctor collaboration and confirmed that more intensive collaboration improved outcomes of importance to patients and to health care managers. Likewise, Lindeke and Sieckert (2005) reviewed nurse - physician collaborative practices and assert that maximising nurse-physician collaboration holds promise for improving patient care and creating satisfying work roles for health care professionals. Weschules et al (2006) carried out research in primary care and hospital set ups and confirmed that improved patient outcomes have been demonstrated in studies of collaboration between pharmacists and physicians, and when pharmacists are included as part of the health care team.

The benefits of interprofessional working have been discussed in various health care settings and specialties. Interprofessional care is considered as an effective approach of collaborative practice and joint working that serves the multi-dimensional and complex health and social care needs of elderly population (Goldsmith et al 2010*)* and service users with mental health problems (Griffiths, 1997; Kates and Ackerman 2002). Holland et al (2005) conducted a study to determine the impact of multidisciplinary interventions on hospital admission and mortality in heart failure and confirmed that multidisciplinary interventions for heart failure reduce both hospital admission and all cause mortality. Likewise, McAlister et al (2004) conducted research to determine whether multidisciplinary strategies improve outcomes for heart failure patients and found that multidisciplinary strategies for the management of patients with heart failure reduce heart failure hospitalisations. Similarly, Birkeland et al (2013) carried out a national exploratory study by employing a mixed methods approach in Swedish paediatric

cardiology teams and concluded that interprofessional teams were required to manage complex cases in paediatric cardiology teams. They further highlighted that improvements in structure, leadership and the presence of medical professionals in paediatric cardiology team were required for the successful delivery of interprofessional care in paediatric cardiology.

O'Leary et al (2010) conducted an interventional study to assess the impact of an intervention, structured inter-disciplinary rounds on hospital care providers' ratings of collaboration and teamwork and concluded that a greater percentage of nurses gave high ratings to the quality of collaboration with resident physicians on the intervention unit as compared to the control unit and providers on the intervention unit rated the teamwork climate significantly higher as compared to the control unit. They further reported that the difference was explained by higher teamwork climate ratings on the part of nurses on the intervention unit.

Jones and Jones (2011) carried out an ethnographic study of an interprofessional initiative in an acute hospital ward in Wales and found four positive effects of better interprofessional working: the emergence of collegial trust within the team, the importance of team meetings and participative safety, the role of shared objectives in conflict management and the value of autonomy within the team. Wheelan et al (2003) confirm that in a critical care setting staff members of high-performing units also perceived their teams as more structured and organised than staff members of lower-performing units. Randomised control trials to assess the effects of interventions designed to improve nurse-doctor collaboration conclude that increased collaboration improves outcomes of importance to patients and to health care managers (Zwarenstein and Bryant, 2000). Sorbero et al (2008) confirms that studies of interventions to improve teamwork

and communication generally show promising effects of improved teamwork on the quality-of-care processes.

Pype et al (2013) conducted a qualitative study by employing a grounded theory approach and conducted five focus groups with 29 general practitioners to examine health care professionals' perceptions toward interprofessional collaboration in palliative home care in Belgium. They concluded that health care professionals' competency, their team arrangements (e.g. co-ordination, assignment of roles and responsibilities) and communication within the interprofessional team are three major factors that influence the quality of interprofessional collaboration and the quality of health care. This study further highlighted that knowing each other's expertise is not sufficient and the role specific competencies of health care professionals are of great value as health care professionals tend to delegate their specific tasks to other professionals. This study was carried out in three groups of health care professionals in palliative health care and did not cover wider health care specialities and health providers. Therefore, the findings of this study have to be interpreted in a specific context with keeping these factors in mind.

Enderby (2002) carried out a quantitative study in community rehabilitation teams in the UK to assess various factors affecting teamwork in rehabilitation teams. She concluded that teams were affected by various factors such as clarity in roles of health care professionals and a lack of knowledge about team structure and functioning which were attributed to the different languages, practices and cultures of the health care professional groups involved. A similar finding was reported by Freeman et al (2000) in a case study research to assess the issues around professional interactions. They reported that the perceptions held by individual health care professionals engaged in interprofessional working collectively shaped shared goals, influenced interactions and role understanding, thereby affecting the team functioning.

Reeves and Lewin (2003) conducted an interventional study on ward based medical teams to respond to concerns about the lengthy ward rounds, difficulties for medical staff in getting to know ward based teams and inefficiencies due to medical staff having to move between wards. They assessed the understanding of activities of health care professionals by providing an in-depth account of interprofessional working on five medical wards in a large teaching hospital in London and reported the following positive impact:

- *Increased the geographic proximity of doctors to other professionals,*
- *Enhanced interprofessional rapport and teamwork between directorate staff.*
- *Increased the number of face-to-face interprofessional interactions between the different staff groups*
- *Improved pharmacy-doctor relations, characterised by a more proactive rather than reactive approach to discussions around medication;*
- *Greater familiarity of doctors with the roles of occupational therapists;*
- *Greater confidence among nurses regarding participation in medical ward rounds and their interactions with doctors more generally.*

(Reeves and Lewin, 2003; p.52)

The following benefits of interprofessional working from the selected initiatives in mental health (Kates and Ackerman 2002) and primary care (Nolte, 2005) in Canada have been identified:

- improved communication and partnerships among all health providers and patients (Nolte, 2005; and Kates and Ackerman 2002);
- clarity on the role of all health providers working within team environments (Nolte, 2005);

- better response processes in addressing determinants of health (Nolte, 2005);
- improved co-ordination in the provision of health care services (Kates and Ackerman 2002);
- high levels of satisfaction on delivery of services (Kates and Ackerman 2002)

There are few studies conducted to compare the benefits of multidisciplinary teams and interdisciplinary teams. Korner (2010) carried out a study to compare multidisciplinary and interdisciplinary team approaches concerning team process and team effectiveness (team performance and staff satisfaction) in German medical rehabilitation clinics and found that teamwork and team effectiveness are higher in teams working with the interdisciplinary team approach. Another study by Hibbert et al (1994) showed higher levels of satisfaction in a nursing team when nurses work according to the interdisciplinary team approach as opposed to the multidisciplinary team approach. The finding of these studies indicated that interdisciplinary teams are superior to multidisciplinary teams, which is in line with the theoretical assumptions.

However, Robertson (1992) describes the following five situations in which multidisciplinary care teams offer advantages over mono-disciplinary medical care teams:

- When advice from other health care professionals are required to a comprehensive review and assessment of the patients health and social need
- When sharing information is considered of mutual benefits
- When future care or treatment must be negotiated with other health care professionals
- When different interventions must be co-ordinated with various professionals

- When interaction between patient, caregiver and health care professional is required.

Interprofessional care is only one of many potential factors and contributors to improved quality of care and clinical outcomes. Schmitt (2001) conducted an experimental study of interprofessional team interventions and confirmed that many other factors (e.g. skill mix, increased treatment intensity, demonstration effect and settings where the interprofessional working occurs as a part of specialised unit), confound the ability to attribute the outcomes to a collaborative effect of the intervention (pp.47-66). Biggs (1997) states that interprofessional care teams help to bridge gaps and reduces discontinuation of services, clarifies roles and responsibilities, delivers comprehensive and holistic services, achieves greater efficiency in the use of resources and improves standard of service delivery. Colyer (2012) describes that the need of interprofessional working in health care is a function of the rise in the number of professions and a result of the increasing complexities of health care practices. Davoli and Fine (2004) suggest that team collaboration assures effective means of improving health services through shared decision making. Ulloa and Adams (2004) highlight experiences from organisations using the team approach for improving performance have pointed to teamwork as an important tool in business success. This finding has prompted organisations to start looking for teamwork skills in their employees.

Keleher (1998) carried out research on the implications of collaborative practices on midwifery and claimed that when doctors and midwives worked together the quality of health care provided to service users exceeded than when it was provided alone. Kelecher further states that there is enhanced satisfaction on the part of women and their families and greater job satisfaction for the professionals. Crozier (2003) asserts when health care professionals work and learn together, there is an improvement in communication and

working relationships. There are, of course, benefits to service users with regards to improved quality of patient care and less duplication of work as described by Pirrie et al (1998). In the United States, the Joint Commission on the Accreditation of Health care Organisations (JCAHO, 2012) requires evidence of interdisciplinary collaboration in hospitals, nursing homes and clinics as part of its accreditation review process.

Ulloa and Adams (2004) highlight that experiences from organisations using the team approach for improving performance have pointed to teamwork as an important tool in business success. This finding has prompted organisations to start looking for teamwork skills in their employees. Any move towards a greater integration and co-operation between agencies and practitioners may bring benefits, but it also creates tensions that need to be recognised and overcome for successful working relationships to be maintained. Central are the issues of accountability and philosophical approach to service provision. Failure to bridge the gap between these two key areas may result in dysfunctional teams and compromised quality of patient care. In order to address this, a facilitative process for exploring and resolving those differences is essential (Fitzsimmons and White, 1997).

From the discussion in the section above, it is observed that the general consensus among health care professionals is that interprofessional working improves services for users. Contrary to this, few researchers have pointed out that interprofessional working creates conflicting situations rather than promoting co-operation and are frequently distorted by mutual suspicion, lack of trust, hostility and disparities between the ways that different professions view themselves and others (Griffiths, 1997; Opie, 1997; and Cott 1997). Similarly, Wachs (2005) describes that teamwork can be time consuming and difficult if attention is not given to the role of team leader, necessary skills of team members, and the importance of an supportive environment.

Empirical research has demonstrated that more positive health care outcomes are achieved by collaborating interprofessional teams (Pollard et al, 2005; Dow and Evans, 2005; Ritter, 1983; Biggs, 1997; Miller et al, 2001; Leathard, 2003; CHSRF, 2006; Nolte, 2005; Byrnes et al, 2009; EICP, 2005; Holland et al, 2005; McAlister et al, 2004). Interprofessional working in health and social care is being viewed as a means to improving quality of care and patient safety at different levels in different countries (DoH, 2008, 2010c; Health Canada, 2005; Institute of Medicine; 2011; JCAHO, 2012).

There is emerging evidence that service users are benefiting from the new ways of joint working and interprofessional working. To summarise, the importance of interprofessional working has been documented within a wide range of health care settings and teams including: maternity (Crozier, 2003), primary care (Shaw et al, 2005; Dianne et al, 2008); GP practices (Dent & Burtney, 1996; Hansson et al, 2008); mental health (Griffiths, 1997; Kates and Ackerman 2002); care of the elderly (Moore et al, 2012); intensive care (Lingard et al 2004; Wheelan et al*;* 2003; Kydona et al, 2010), long-term care (Cott, 1997; Tourangeau, 2010), operating theatre (Makary et al, 2006), inpatient ward (O'Leary et al 2010), orthopaedic outpatient department (Edmondston et al 2012) and palliative care (Street and Blackford, 2001). The scope of joint working, communication and interactions between members in interprofessional care teams is certainly greater than services provided by an individual member outside the health care team (Pecukoni et al, 2008). It shows that there is so much literature published to describe the benefits of interprofessional working to different health care settings and teams.

However, it is observed that there is no comprehensive research carried out and reported in developing countries to investigate the benefits of interprofessional working and collaborative practice to service users. Furthermore, most of the research is focused on the impact of interprofessional working that is carried out in developed health economies

on clinical outcomes (West, 2002; O'Leary et al, 2010; Wheenan et al, 2003; Booth & Hewison, 2002; Edmondston et al, 2011; England & Evans, 1992; Finkler & Correa, 1996; McAlister et al, 2004; Pellatt, 2007; Sorbero et al, 2008; Anderson et al, 1995), quality of patient care (Wagner, 2004; Schmitt, 2001; Pike et al, 1993, Chang et al, 2009; Ferlie & Shortell, 2001; Firth-Lozens, 1998; Fitzpatrick & Boulton, 1994; Kydona *et al*, 2010; May & Pope, 2000; Rafferty et al 2001) and patient safety (Richardson and Storr, 2010; Milld et al, 2008; Manser, 2009; Jones & Jones, 2011; O'Learey et al, 2010; Patient Safety First, 2010; Health & Safety Executives; 1999). There is much research carried out on physician - nurse relationship, collaboration or teamwork (Vogwill & Reeves, 2008; Pike et al, 1993; Baggs and Schmitt, 1988; Barrere & Ellis, 2002; Henneman, 1995; Hojat et al, 2001; King, 1983; Makery et al 2006; O'Brian-Pallas et al, 2005; Way et al, 2000).

In summary, this section of the literature review explored the potential impact and outcomes of interprofessional working. From the review of the literature in the sections above, it is reasonable to conclude that interprofessional working has a great impact on the way health services are delivered and health care professionals work together for service users. However, health care professionals face challenges and barriers whilst working together for the delivery of health care and the following section 2.9 describes the challenges and barriers of interprofessional working.

2.10 Challenges and Barriers of Interprofessional Working

Scholars have pointed out that interprofessional working has led to improvements in outcomes for service users and is essential for quality care but it also poses challenges to the effective delivery of health services (Colyer, 2012; Milburn and Walker, 2009; Fewster-Thuente & Velsor-Friedrich; Reel and Hutchings, 2007; Orchard, 2005; Barrie, 2004; Kenny, 2002; Drinka and Clarke, 2000; Biggs, 1997; Bope and Jost, 1994; Leiba,

1994). Identifying and understanding the sources and scope of those challenges is useful to develop strategies to mitigate the risk to effective service delivery and to promote safer collaborative practice.

According to Drinka and Clark (2000), the interprofessional team is not just a group of different health care professionals working together state, but it is a very complex issue even though it appears simple. Davoli and Fine (2004) agree and claim that health care professionals who preach teamwork may not always be enthusiastic to support it and those professionals who are very organised and well functioning may be chaotic. Biggs (1997) argues that the meaning implied by interprofessional and collaboration is ambiguous. Biggs suggests that the term 'interprofessional' may be used to imply relationships other than those strictly obtaining between professional groups and the term 'collaboration' is interchanged with many other words such as co-operation and co-ordination. A lack of clear understanding of others' roles and scope creates miscommunication and misunderstanding among health care professionals (Fagin, 1992). Enderby (2002) highlights that developing collaborative team working was a real challenge as health care team members may not have the time to get to know each other personally or professionally. According to Barrie (2004) invalid assumptions may lead to breakdown in communication and teamwork, and constitute a barrier in effective patient care. Similarly, Rawson (1994) points out a number of major reasons that hinder interprofessional working in health care such as poor communications and language differences, conflicting power relationships, ideological differences and role confusions (p.39)

Strauss (1962) argues that professionals hold on to their specialist point of view and this creates disputes and semi autonomous sections rather than co-operation in professionalism. Pecukonis et al (2008) agree with this view and describe that

professionalism denotes differences with special knowledge or skills unknown or unavailable to others and promotes competition rather than collaboration. These views are considered as barriers to the development of interprofessional working between various professions.

Chong et al (2013) conducted a qualitative study by using semi-structured interviews among 31 health care professionals in Australia to explore perceptions of barriers and facilitators of shared decision making and interprofessional collaboration in mental health care. They concluded that two main factors namely - factors associated with health care professionals (e.g. professional roles, attitudes, beliefs, knowledge and skills towards facilitating interprofessional collaboration) and health care organisations and systems (e.g. information sharing, leadership, resources, government policies) were recognised as health care professionals' perceived barriers and facilitators of interprofessional working and shared decision making in mental health. Mental health care can be different and challenging in comparison to acute health care and the findings of this study may not be interpreted in the same way that other health care professionals in acute set up perceive the barriers of interprofessional collaboration. They concluded that changes are required at service user, health care professional, health care organisation and system levels to implement successful collaborative practices and shared decision making in mental health care.

Kvarnstrom (2008) carried out a study to identify and describe difficulties perceived by health care professionals in interprofessional working in Swedish health care teams and confirmed that health care professionals identified problems with interprofessional care as having a negative impact on patient care and service. This research documented the difficulties related to the team dynamic that arose when team members acted towards one another as representatives of their professions, difficulties that occurred when the

members' various knowledge contributions interacted in the team, and difficulties related to the influence of the surrounding organisation.

A number of authors have questioned the benefits of interprofessional working and collaboration. Biggs (1997) argues that associations and relationships between health care professionals and between agencies can reduce choices for service users. Biggs further states that interprofessional care in terms of service planning is 'inward-looking' and attention is paid only to service integration. Parton (1985) argues that interprofessional working could prove risky to creative and innovative solutions, as well as conventional tendencies within professional judgement would limit choice to existing services.

Keleher (1998) claims that there is tension in the various approaches to delivery. For instance, doctors are usually patient oriented, responding to a problem presented to them by individual patients; whereas nurses could be described as circumstancing or care oriented, responding by circumstance and their potential for causing future health risks. Similarly, social workers are crisis oriented, reacting to an immediate threat or the damage incurred as a result of a specific incident. The different orientations may manifest themselves in several ways and lead to frictions that can breed hostility and prevent effective teamwork (Fitzsimmons and White, 1997). Leiba (1994) discusses that inter-professionalism is a barrier to the development of interprofessional working and collaborative practice between health care professionals as each group of professionals hold their own specialist point of view and work within the professional boundaries.

Many work environments suffer from a lack of support for collaborative, team-based care, but improved collaboration and teamwork through interprofessional care assist caregivers to work more effectively by helping to manage increasing workloads, reduce wait times and reduce likelihood of patients suffering adverse reactions as a result of the care they receive (Canadian Health Service Research Foundation, 2006). Evans (1994)

argues that a lack of clarity about the nature of interprofessional care teams may cause problems for health care professionals. Onyett et al (2007) suggest that there is a central dilemma within interprofessional care teams, that individual professionals are members of at least two groups - their profession and the team. Orchard (2005) agrees and mentions that identification with these two groups may be conflicting or complementary depending on the practices and culture of the groups (Orchard, 2005). Similarly, Hamidi and Eivazi (2010) state that the variety of inputs from team members may raise conflict, which may lead to increased levels of stress and decreased motivation in order to collaborate in the team work, or it may motivate health care professionals in a more positive manner.

One of the barriers of an interprofessional care team is the different values and beliefs of health care professionals (Reel and Hutchings, 2007; Pietroni, 1992; Hammick et al, 2009, Sullivan, 1998). Hammick et al (2009) argue that differences between professional status amongst health care professionals and groups can create challenges within an interprofessional team. Friedson (1970) explains that the medical profession has long been the dominant professional group and they hold positions of authority in the health care field. They are privileged and are a high status professional group. They exercise control over nursing and allied health professionals' curricula, examinations and professional registration (Hammick et al, 2009). Furthermore, constant changes in the organisation structures and processes impact the levels and capacities of health care professionals (Jehn, 1997). Similarly, Pietroni (1992) states that different health care professionals have different values, beliefs, languages and backgrounds and these factors obstruct the interprofessional working practice in health care organisations. It creates a problem when health care professionals do not want to find out how others carry out their

practices and makes decisions about care planning and management (Parsell and Bligh, 1999).

Another factor to consider when implementing collaboration amongst health care professionals is personal vs. professional interests in the care team. There is a big gap and inequalities in the status, pay and training opportunities between members of various health care professionals (Miller et al, 2001). This factor may have a negative impact on the professional interest and collaborative practices in the interprofessional care team. Each health care professional contributes not only his or her specialist point of view and expertise, but also his or her individual temperament, personality, personal experience and style of communication (Leiba, 1994). According to Leiba, these personal variables in interprofessional working and collaborative practice can have dire consequences, if overlooked. Drinka and Clark (2000) describe that ongoing impact of personal factors such as cultural background, styles, charisma of the member of the team collaboration is unique and these characteristics are downplayed to team collaboration. Beattie (1994) claims professional ambition, competition, territoriality and protectionism are major barriers bringing health care professionals together for collaborative practice.

Bope and Jost (1994) suggest that a lack of trust and honesty amongst health care professionals is one of the biggest culprits of an interprofessional care team. According to Natale et al *(*1998), trust develops over a long period of time and through a process of trial and error. Similarly, Colyer (2012) describes that collaborative practice may fail if health care professionals do not respect and trust each other in clinical practices while delivering health services to service users. Scarnati (2001) states that unsupportive team members can be a cause of the team being inefficient. Hornby and Atkins (2000) highlight failure to communicate, narrow vision, ignorance concerning other agencies and professions, lack of trust and rivalry between face-workers, conflicting opinions and

attitudes, reaction to change and role insecurity as hindrances to interprofessional working. The health care sector has developed or been governed by market mechanism as a market, where growing competition and promotion are observed over the last two decades. This may create a sense of rivalry between health care professionals, rather than promotion of interprofessional care and collaborative practice (Harbaugh, 1994). Furthermore, roles of health care professionals may be considered as part of the occupational competition within the health care sector (Rawson, 1994).

A lack of resources is another factor to consider as a barrier to interprofessional care teams. In many instances, shortages in health care staff (Hamidi & Eivazi; 2010), lack of time or moral support for the health care professionals (Hammick et al, 2009) has an undesired outcome. Without an appropriate amount of resources and well defined objectives, health care professionals cannot achieve their goals, no matter how good their intentions (CIHC, 2009).

It may be a barrier to interprofessional care and collaborative practice if health care professionals have an over strong commitment and they do not accept the autonomy and professional status of others (Colyer, 2012). Hardy et al (1992) mentions five different barriers of working together in health and social care – structural (e.g. service fragmentation and gaps), procedural (e.g. different planning and financial cycles), financial (e.g. different funding mechanism and costs of the services), status and legitimacy (e.g. different status and authority of different agencies), and professional issues (e.g. professional self-interest, competition, values and ideology) (Hardy et al 1992, quoted in Leathard, 2003, p.7). Haire (2010) has summarised the challenges related to the implementation of interprofessional care and teamwork in the key three elements of the process - partnership, communication and collaboration. Hansen and Nohria (2004) state four barriers to collaborative practice. According to them, unwillingness to seek

input and learn from others, inability to seek and find expertise, unwillingness to help and inability to work together and transfer knowledge are the main barriers of multiunit collaborative practices. Leathard (2003) reports that different academic background, lengthy and time consuming consultation, organisational and professional boundaries and loyalties, inequalities in status and pay and lack of clarity about roles and responsibilities are pitfalls of interprofessional practice.

Reel and Hutchings (2007) describe that ineffective leadership, poor or lack of communication, mistrust, egos and various members having different values and beliefs are some of the problems that occur within interprofessional care teams (p.142). Similarly, Delva et al (2008) recognises a number of barriers to team effectiveness including absenteeism, disorganised teams, too little time for team building and unwillingness to accommodate fellow team members. Colyer (2012) states that relations between health care professionals due to conflicting personalities may create a problem for collaborative practice as it is recognised as a hurdle in promoting and maintaining good relationships. It is a very challenging task to create a favourable environment if all health care professionals do not want to be a part of the complex team process if they are not willing to share their knowledge, skills and expertise and are not willing to respect the perspective of other professionals (Goldsmith et al, 2010).

Kenny (2002) carried out a study on interprofessional working in children's nursing to examine challenges and opportunities. Kenny argues that possible inhibitors to interprofessional working exist at inter-organisational levels (e.g. differences in power and resources), interprofessional levels (e.g. actual or perceived differences in status, training and skills) and interpersonal levels (e.g. the race, class and sex of participants) and suggests that each can affect others as none of these exist independently. Similarly,

Fewster-Thuente and Velsor-Friedrich (2005) describes patriarchal relationships, time, gender, lack of role clarification and culture are the barriers to interprofessional working.

Hornby and Atkins (2000) suggest that defensive organisational behaviours can have a negative impact on the interprofessional working relationships and the multi-professional practice. Finley (2000) argues that attending to the needs of the team for sustainable cohesiveness can lead to team members becoming self-absorbed and unduly focused on team relationships, putting these ahead of the needs of service users. Millar et al (2001) suggest that different team members in the same team of health care professionals can have a different and conflicting understanding of the nature of effective teamwork and interprofessional working. Miller et al's study on interprofessional practice highlights issues concerning the way clinicians communicate, their understanding of different roles and their awareness of the impact of management and organisational policies on the interprofessional care team.

It is acknowledged that interprofessional working may bring some inherent risks due to structural barriers, differences in health care professionals' cultures and philosophies (Gerardi, 2005). Some of the key challenges and barriers to interprofessional working can be summarised and grouped into the following three groups:

- Professional: Different levels of authority or power, professional autonomy, professional boundaries, specialised skills and designated roles, inflexible teams, lack of trust and honesty,
- Behavioural: Attitudes, ego, personality and behaviours.
- Organisational: Organisational structure, hierarchy, processes, policies, limited flow of information between teams (Evers et al, 1994), miscommunication or lack of communication.

It is discussed in the sections above that interprofessional barriers may create confusion and conflict and it may have a negative impact on the outcome of interprofessional working. To implement an agenda of effective interprofessional working for service users and health care professionals, health care professionals need to overcome all barriers in order to achieve shared goals and optimal desired outcomes.

2.11 Summary

Interprofessional care involves joint working and interactions between health care professionals. For interprofessional care to happen in practice, health care professionals share their knowledge, skills and expertise (WHO, 2010) and make joint decisions based upon the shared professional viewpoints (Canadian Interprofessional Health Collaborative, 2010). The interprofessional working and interaction with other health care professionals may help a health care team to develop clinical and administrative strategies for service users and team function. Interprofessional working between health care professionals brings all professionals and organisations together to deliver effective health services (Carlton, 1984). Interprofessional care envisions that health care professionals as 'effective communicators and professionals committed to working collaboratively' to deliver the best possible care (Health Force Ontario, 2010).

From the literature review, it can be concluded that health care teams vary on structure, purpose and composition. Interprofessional working is influenced by the way a health care team is structured. Organisational factors have great impact on the development of interprofessional care teams. According to the literature, interprofessional care teams thrive in a supportive organisational environment, and the organisational context influences the structure of interprofessional care teams. The literature suggests that health care professionals play various roles such as personal, professional and task roles. From the literature review, it can be concluded that roles may be overlapped between various

professions and hidden roles may create misunderstanding between health care professionals. It is also suggested that roles of health care professionals vary within the legal and organisational boundaries.

Previous research suggests that health care professionals require a range of personal, professional and interprofessional competencies to work effectively in interprofessional care teams and they learn skills and competencies through shared learning and from each other. From the literature it can be concluded that interprofessional care teams are mostly led by medical professions, they can influence the decision making process and play vital roles in the management and delivery of the health care services. The previous literature also suggests that service users' involvement in decision making improves clinical and health care outcomes. It is also suggested that decision making in health care team is mostly done by consensus and ownership of decision are taken by health care professionals.

From the literature review, it can be concluded that effective communication and interaction improves clinical outcomes and there is a negative impact of poor communication on safety and work process. It is also suggested that the effectiveness of team communication and performances depend on the way health care professionals communicate and interact.

Previous research suggests that professional identity is shaped by qualification, experience and social factors. Furthermore, it can be suggested that professional identity comes from the roles and individual identity supplement to form professional identity. Previous research also suggests that health care professionals tend to be autonomous by their nature of work as they can make independent judgements. It is suggested that health care professionals value professional autonomy and the level of autonomy is not the same throughout their career. It can be concluded that professional boundaries are defined by

their respective areas of expertise and practices and health care structures or set ups have an impact on the development and regulation of professional boundaries.

From the literature in the sections above, it is observed that the general consensus among health care professionals is that interprofessional working is beneficial to service users, health care professionals and systems as it improves quality of care and patient experiences. Furthermore, it can be concluded that interprofessional working has a positive impact on the way health services are delivered. However, previous research concludes that there are various personal, professional and organisational barriers to interprofessional working. The most commonly mentioned barriers to interprofessional working are differences in professional status, personal styles, background, lack of trust and honesty, bureaucratic layers, service users' expectations, lack of resources, lack of training and education, miscommunication, egos, unwillingness to participate etc.

Chapter 3: Professional Power in Interprofessional Working

3.1 Introduction

Health care professionals work within the framework of professional councils, regulatory bodies and health care organisations. Understanding professions, professional power, interprofessional relationships and interdependencies between health care professionals is important because these factors impact on the way health care professionals work. Knowledge about professions and power in health care organisations is also of importance for health care professionals and it is equally relevant to their work. Health care professionals use power and authority while delivering health services, which is a subject of discussion in social sciences. With the rise of professions and interprofessional practice in health care, discussing and examining the theory of professions and professional power of health care professionals is appropriate.

One of the important aspects of professions and their interaction is different levels of power. Not every professional has the same level of power and the same level of influence. Hence, the question where does health care professionals' power come from and how does it play a role in the delivery of health care is important to discuss in this chapter. Professionals in health care are considered to be powerful and influential groups. Profession is also part of social and organisational structures. Health care professionals exercise control and autonomy and they also have privilege, authority and power to deliver health services. Health care professionals' authority and power are specified in regulations; organisational policies, papers and structures. They are authorised to deliver health services through the licensing system. However, the authority, power and privilege of different health care professionals is not the same as there are differences between their roles, the way they work and the way different professions are organised and

structured. Different health care professionals may perceive different levels and amounts of power in relation to health care delivery to different service users at different points and contexts. Health care professionals may be concerned with relative power in defining their roles and authority. Therefore, the influence of health care professionals in health service delivery, professional power and dominance comes into the scene.

The purpose of this chapter is to demonstrate the understanding of professional power perspectives of theory of professions and to explain the reason for choosing the approach. Therefore, it starts with the justification of choosing professional power as the main theoretical concept of professions for this study. This chapter also describes the theory of professions and the professional power approach of professions including the critical analysis of the professional power perspectives of the theory of professions.

3.2 Professional Power and Interprofessional Working

Professional power is the capability and expertise to perform a task in an appropriate way. Professional power may come from different sources such as regulation, law, professional code of conduct, common practice, knowledge, skills and expertise. In this sense, professional power is the capacity and authority to mobilise resources in the interest of achieving organisational goals. Pearson (1970) states that the central phenomenon of any organisation is the mobilisation of professional power to achieve organisational goals. The overall system authorises the organisational goals and objectives, but it is only through professional power that its achievement can be made effective.

One of the objectives of this study is to examine professional power perspectives of the theory of professions in relation to interprofessional working. The professional power perspective on professions has been chosen in this research as a theory. There are a few

reasons for choosing this approach. Health services are dynamic and ever changing. There are many specialities and sub-specialities emerging. The professional power perspective of the theory of professions recognises the emergence of new professions by recognising new knowledge, expertise and specialties in health care (Johnson, 1972).

It is an obvious observation that there are differences in roles, background, tasks and schedules between medical, nursing and allied health professionals. Interprofessional working reflects the diversity and adds different professional perspectives acquired through different types of education, training, experience and practice (Hammick et al, 2009, p.46). This learning perspective may enhance knowledge, skills and expertise of health care professionals and may be linked with the sources of power. Therefore, it is important to assess this aspect of theory of professions as well. Effective interprofessional working may strengthen the power, responsibility or the status of health care professionals and they may gain recognition and status. Interprofessional working involves sharing one's expertise and relinquishing some professional autonomy to work closely with others, including service users and communities, to achieve effective delivery of health care and better outcomes (IPEC, 2011).

Research scholars and authors confirm that medical dominance is a feature of division of labour in health care (Freidson, 1970; 1970a; Johnson, 1972; Corner, 1997). It is an interesting idea in health care to examine how medical dominance over other professionals affects interprofessional working relations between various groups of health care professionals.

Duncanis and Golin (1979) argue that professional standards of ethics and training are set through various professional organisations and associations. These organisations also set requirements for certification and licensing and implementing them through legitimisation of power and the perpetuation of autonomy. Professional councils set

standards for their members by working closely with health care organisations, government bodies and educational institutions to deliver safe and effective health services, to protect service users and to improve clinical practices (GMC, 2012; NMC, 2012; HPC, 2008). The expansion of roles of health care professionals has increased in response to a mixture of pressures from a professional, social and political perspective in health care in the last two decades (Humphries and Masterton 2000). Therefore, it is relevant to see how health care professionals perceive this in the context of developing health economies as there are many new technologies, specialties and health services introduced in recent decades.

Finally, the professional power perspectives of theory of professions is an action oriented analysis of professions and their barriers. Therefore, this professional power approach of theory of professions fits within the research question as this study also aims to find out gaps, challenges and barriers and to recommend ideas for improving interprofessional working in Nepalese hospitals.

The professional power perspective of theory of professions fits with this study since this perspective focuses on relationships between various groups of health care professionals' power, autonomy and control and the possibilities for health care professionals to apply such expertise within their daily practice. The following section in this chapter describes the essence of professional power perspectives of the theory of professions and its relevance to interprofessional working.

3.3 Theory of Professions

It is important to describe the theory of professions and its attributes to understand the meaning and features of professional power perspectives of the theory of professions. The theory of professions is described in many ways in the context of social sciences and

health care (Freidson, 1970a & 1986; Larson, 1977; Duncanis and Golin, 1979; Barr et al 2005; Hoogland and Jochemsen, 2000). The theory of professions has evolved as a strong concept in social sciences and health care in the last few decades due to the increase in specialisation and sub-specialisation in health care and development of various fields or expertise in medicines, nursing and allied health professionals. Theory of professions and its influence in society and medicines has been described by Freidson (1970a, 1970b) and Johnson (1972).

Freidson (1970a, 1970b) conceptualises professions based on the organisation of labour, and furthermore differentiates professions from occupations. Professions need specialised knowledge and extensive training. Profession is regulated, tends to be autonomous and the responsibilities lie with the individual professional. On the other hand, occupations do not need such extensive training, are not regulated and need to be supervised by seniors. Freidson describes that the application of knowledge is important in professions and the jurisdiction of professional control arises from the professional monopoly.

Johnson (1972) analyses the profession in detail and argues that professionals control their work and impose their own definitions of need and the type of service they offer. Freidson (1970a, 1970b) and Johnson (1972) developed a new and critical way of defining the theory of professions. Freidson and Johnson view professions as power and describe an approach in the theory of professions to receive and sustain power through the structures and processes in the society. Freidson and Johnson further argue that professions develop and maintain work authority and monopolies for the benefit of members. Freidson and Johnson highlight an important aspect of professions based on the promotion and use of knowledge and expertise. According to this concept, health care professionals support each other by bridging the gap in knowledge and by playing supportive or complementary roles in the complex delivery of health services.

The theory of professions may be seen in a context to create an environment for rivalry and competition between professions in health care. Abbott (1988) mentions that a competitive environment has a greater scope of practice between professions and understanding relations between professions; and between professions and the state. However, the principles of competition may somehow contradict with interprofessional working and collaborative practices and the theory of professions may be seen as a barrier to interprofessional working in health care from this perspective.

There has been advanced development in health and medical sciences due to the emergence of a specialisation and a super specialisation era, expansion of knowledge and availability of various modalities of services and treatment. These rapid changes in health care led to a division of labour between health care professionals, development of task specific roles, introduction of various means and ways of interaction and communication for interprofessional care and collaborative practices between health care professionals. In the context of interprofessional care; the health care professionals' technical and clinical knowledge is the broader guiding principle for clinical practice and health service delivery. Irvine et al (2002) argue that it is difficult to understand the context and concept of interprofessional care without appreciation of the multiplicity of this subject, both between health care professions and within them.

To summarise, the theory of professions addresses the division of labour and the different professions who control and manage their work based on their skills, competence, training, registration and professional conduct. Power, status and authority are essential for professions. A profession gains a full status and identity when any occupation goes through various stages of training, education, qualifications and more importantly the recognition by a regulatory body or authority. Interprofessional care attracts, follows and

recognises professional power. The following section describes the concept of professional power as perceived in the theory of professions.

3.4 Professional Power in Theory of Professions

Freidson (1970a) focuses on the 'power' aspect of professions and explains that it has a great influence in determining professional behaviour and dominance. Freidson mainly focuses on the power and influence of medical professionals on a health care delivery system. Power of medical professionals, due to their knowledge, expertise and roles is one of the well established characteristics of health care delivery (Hugman, 1991; Elston, 1991). Medical professionals influence health care delivery systems, organisational culture, professional practice and ethos through accountabilities, position, power, authority, and hierarchy (Gillespie et al, 2002). According to Klein (1989), the medical professionals' keep a close relationship with health service policy makers which helps to allocate better resources and solve issues related to their professions. There are many external and internal factors, such as community and service users' engagement, competition, financial strategies and other policies that may influence health care delivery. Freidson's professional power approach does not consider all these factors. Therefore, there may be other factors associated with professional power that may contribute and may have influence on professional behaviour.

Freidson (1970a) asserts that professional power of medical professionals comes from autonomy; and they become dominant over other professions. He describes autonomy as the capability to control jobs and dominance as control over the jobs of other health care professionals; he highlights that autonomy and dominance are two pillars of professional power. Similarly, Freidson (1970a & 1970b) and Johnson (1972) describe professions as a major source of power through client and professional relations. This approach

describes how professions get the power base from the client, but ignores the distribution of power between health care professionals for better interprofessional relationships.

Later on, Foucault (1980) also highlights the relationship between knowledge and power in professions and states that '*knowledge is inextricably entwined in relations of power and advances of knowledge are associated with advances and developments in the exercise of power*' (Foucault, 1980, p.64). Foucault (1980; 1986) asserts that knowledge is a source of power; and power cannot be separated from knowledge. He further states that communication and records are a part of knowledge and they are linked to power. According to Foucault (1986), discourse is required for using power, through which knowledge and subjects are constituted. Foucault argues that power is essential in order to bring change in the society and in the behaviour of individuals or professionals.

Abbott (1988) states that production of knowledge and institutionalisation of a body of knowledge into occupational groups and disciplines can be viewed from the perspective of sociology of professions. This concept focuses on links between institutions, knowledge and authority or power. Health care professionals get training and education in a specific discipline in educational institutions and they gain knowledge and expertise in their field. Fackler et al (2015) state that knowledge gained by professionals may be 'the first step towards exercising power'. The state, through professional councils legitimise health care professionals' knowledge, recognise and authorise them as a profession to deliver health services. This is one of the ways professional councils control their members, state and organisations manage the health care work force and health care professionals deliver health services. Polifroni (2010) states that specialised knowledge grants expert power to professionals and they exercise their power by virtue of their knowledge and expertise. Professional roles, responsibilities, knowledge and skills can

make health care professionals powerful and they can use their expertise over service users to alleviate service users' health problems or to improve their conditions.

Knowledge is linked with self-confidence, respect, recognition, engagement and collaborative practices through the use of authority and power. Faclker et al (2015) explored hospital nurses' lived experiences of power and conclude that nurses believe power develops through acquisition of knowledge, experience and self-confidence. This study further highlights that nurses felt powerful when their voices were heard, they took part in interprofessional rounds and collaborative practices by agreeing care plans together with physicians for service users, they were perceived as trusted and respected, and they were acknowledged by families, physicians and administration. Moreover, Fackler et al assert that when nurses felt powerful, they were visible to others and they were willing to take various roles such as the leader, mentor, committee member and role model.

One of the fascinating aspects of interprofessional team collaboration is power sharing and authority (Irvine, et al, 2002). Interprofessional working empowers health care professionals by giving them active roles in decision making. All health care professionals enjoy a high status in society and self-esteem. The higher self-esteem and status comes from their social function of their clinical work, education, experience and expertise as they are highly specialised and skilled. Health care professionals have power, which is used to control their areas of clinical expertise and interests. Larkin (1983) asserts that a profession tends to control and protect its area of skills or expertise and the conduct of its members. Health care professionals may exercise a dominating influence through professional power over their entire clinical field. Hansson et al (2008) argue that health care professionals' self-perception has to be considered to implement successful

teamwork, as has the prestige and status associated with their traditional role and the benefits of teamwork to the profession of medicine.

Pollard et al (2005) suggest that a central aspect of interprofessional working concerns the relative power of different professional groups. Hemmeman et al (1995) assert that power sharing and non-hierarchical structures are two principles of effective interprofessional collaboration. Differentials in professional power may arise from expertise, roles and credibility of an individual or a group involved in an interprofessional care team. It is not possible to have an equal share of professional power. Therefore, the sharing of power should be based on the need of service users or the nature of the task. Barrett and Keeping (2005) suggest that power differentials must be acknowledged, recognised and resolved for successful interprofessional care.

Henneman (1995) asserts that health care professionals in collaborative practice share power based on knowledge and expertise. Kappeli (1995) states that power is central to the concept of collaboration and co-operation. According to Sullivan (1998), active contribution, respect to team members and contribution of all parties involved are the three main features that define power. Sullivan asserts that collaboration is a dynamic and transforming process of creating a power sharing partnership. As part of power sharing in health care organisations, health care professionals engage in the formation of shared objectives, decision making and problem solving.

Professional power perspective of theory of professions also focuses on the loss of power of medical professions due to the emergence of new professions, bureaucratisation and corporatisation (Johnson, 1972; McKinlay, 1975). Freidson (1994) also recognises the emergence of new professions in health care. However, Freidson claims that medical professionals are still considered the most dominant and powerful professionals in health care; and medicine has not lost the charm and significant component that makes it a

dominant profession. Changes within professional groups due to social and organisational changes challenge traditional power relationships in the field of health care, especially the dominance and power of medical professionals (Gillespie et al, 2002).

Freidson (1970a) introduced the concept of professional dominance in health care and claims that medical professionals control the content of the medical profession by expertise, knowledge and clinical practice and also influence the development of policies and strategies in health care. Dominance of medical professionals in health care is seen as one of the principles of organising and managing health service (Adamson et al, 1995). Traditionally the delivery of health care was based on medical paternalism and medical professionals were the key players and decision makers in health care (North, 1997). However, increased autonomy and independence of new and developing professionals in health care is thought to be a major challenge to medical dominance.

Freidson, (1970a; 1970b) states that professional autonomy and the resulting necessity for self regulation are key features of 'true' professions. However, Freidson's concept of autonomy is largely practised at the 'personal level' as an individual and as an accountable and responsible health care professional. Control is maintained through regulation and is largely over the shoulder of professional bodies and councils. Code of practice, requirement for registration, professional ethics, fitness of practice and validation are the means for maintaining control over professions (Freidson, 1970a & 1970b; Canning and Dwyer, 2001; Clarke, 2007). According to Freidson, autonomy and control are core elements of maintaining good relations with other professionals in health care. Rafferty et al (2001) confirm that there is a strong association between teamwork and professional autonomy in health care which could create synergy, rather than conflict. One of the criticisms of autonomy is that there may be a conflict of interest as it

does not fit well between the concept of self-interest of professionals and moral aspect in relation to the delivery of fair health services to community and service users.

Increase in professional autonomy means '*a decrease in the dominance of the corresponding individual or group in the relationship*' (Ovretveit, 1985; p.78). Nursing and other allied health professionals were considered as subordinate to medical professionals and they experienced medical dominance and were weak in comparison to medical professionals (Etzioni, 1969). Parkin's (1995) argues that nursing professionals struggled to develop their own 'separate and unique body of evidence' due to dominance of medical professionals. However, due to recognition of contribution made by nursing and allied health professionals in the delivery of health services, they are equally accountable and responsible for health service delivery and have authority in their respective fields. Due to the advancement in clinical knowledge, diagnostic and therapeutic technologies and recognition of sub-specialties in health care; medical professionals are becoming less homogenous (Gabe et al, 1994). As a result, medical professionals are dependent on nursing and allied health professionals and all health care professionals gain the status of true profession. This may be one of the reasons for changing boundaries between health care professionals. Moreover, managerial and bureaucratic control over health care professionals encourages change within the boundaries between health care professionals (Chamberlain, 2010).

Dominant professional groups within society control decision making process under the structuralism concept (Alford and Friedland, 1985). Weber (1947) highlighted power and domination in a wider context of social and political structures and there is no context of health care organisations and interprofessional relationships. Clegg (1989) asserts that the main focus of organisational theory of power is defined within the limited boundary and context of '*politics*', and the '*cause of power is resource dependency*' (Clegg, 1989,

p.190). In this context, organisational theory of power is linked with the concept of interprofessional working, which is mainly based on sharing resources (i.e. knowledge, skills and expertise); and learning from each other for the benefits of health care professionals and service users.

In summary, the key concepts of the professional power perspectives of theory of professions are:

- Profession is a source of power and professional power has a great influence in determining professional behaviour and dominance (Freidson, 1970a; 1970b);
- Professional power of medical professionals comes from autonomy; and they become dominant over other professions (Freidson, 1970a).

This research examines these two key concepts of professional power perspectives of theory of professions in relation to perceptions of health care professionals on interprofessional working in health care.

3.5 Summary

This research follows the professional power perspectives of the professions as described earlier in this chapter to examine how health care professionals collaborate and to assess their perceptions on interprofessional working in health care. The main reasons for choosing power perspectives of theory of professions as a theoretical base for this research are a) theory of professions recognises emergence of new professionals; b) differences in roles, background, tasks and schedules between medical, nursing and allied health professionals; c) power or status differences between health care professionals; and d) power perspectives of theory of professions is action oriented and one of the objectives of this research is to assess gaps in interprofessional working and to recommend ways to improve interprofessional practices.

This chapter introduced the theory of professions. The theory of professions is division of labour of different professions who control and manage their work based on their skills, competence, training, registration and professional conduct. Moreover, this chapter discusses Freidson and Johnson's view on professions as power based on the promotion and the use of knowledge and expertise.

This chapter also described the professional power perspectives of the theory of professions. 'Professions' are seen as a source of power (by the use of knowledge, skills and expertise) in professional power perspectives of theory of professions, which mainly focuses on control over professions, dominance, autonomy and professional relationships. According to this approach, health care professionals gain such professional power from knowledge, training, education and from their interprofessional team and organisations, and professional power has a great influence in determining professional behaviour and dominance. As a result of advancement in therapeutic technologies, emergence of new specialities in health care and managerial control, power dynamics between health care professionals are changing. Relative power between health care professionals is evident and health care professionals complement each other for flawless health services and learning from each other.

Chapter 4: Research Methodology

4.1 Introduction

Previous chapters covered the literature review and theoretical construct that guided this study. This chapter discusses in detail the methodological choice and the research design process of this study based on the research purposes and research questions. Specifically, this chapter provides a clear rationale for the research design and describes the reasons for the choices of methods used for the study, including likely benefits, weaknesses and barriers of this strategy. Furthermore, this chapter discusses details of the research methodology including research design, sample, reliability, validity, ethical considerations, data collection and analysis methods.

4.2 Rationale

This research is carried out by using qualitative methods as there is a focus on depth, detail and context within this research approach. A qualitative research approach is mostly holistic, naturalistic and realist. It is based on the fact that knowledge about humans is not easily understood without describing experience as it is lived and defined by the actors themselves (Polit and Hungler, 1999). Qualitative research is considered an appropriate approach for this research for the following reasons:

Firstly, perceptions of health care professionals on interprofessional working in health care delivery were assessed. Therefore, subjective information and data are more relevant to explore depth and detail through multiple perspectives. Qualitative research methods help to actively engage health care professionals for further discussion and to reflect on their experiences and accounts. Secondly, interprofessional care is a very complex issue (CIHC, 2009) and this study examines how health care professionals collaborate in Nepalese hospitals. Examining complex issues like this would be difficult with

quantitative methods. To gain insight into complex social phenomena it is necessary to get perspectives of insiders and not reduce them to a dimensional unit (Bryman and Bell, 2011). Finally, as described by Bryman and Bell (2011), 'qualitative research tends to view social life in terms of processes'. Mason (2002) also stressed processes in qualitative research were seen to be appropriate to the research questions which are concerned with the factors that support and hinder interprofessional working in Nepalese hospitals and how different health care professionals collaborate to deliver the best possible health care in hospitals.

The statements above explain the main justification for choosing qualitative methods in this study as this research seeks in-depth, detailed actors' accounts that recognise the variety and complexity of experiences and perceptions of health care professionals in interprofessional working.

The use of qualitative research methodologies provide the following advantages:

- Qualitative research provides detail and depth of understanding and a means of examining unquantifiable facts (Berg, 2001). He further suggests that it seeks answers to questions by examining various settings and actors.
- A qualitative method is an effective approach for studying behaviour and perceptions and for exploring social processes over time (Babbie, 2004). The author further highlights greater validity as important benefits of qualitative approaches.
- Bryman and Bell (2011) highlight flexibility due to preference for a 'loosely structured approach' to the data collection in qualitative research approach.

However, researchers and scholars highlight different shortcomings and criticisms to qualitative approaches. Bryman and Bell (2011) mention mainly four criticisms to the

qualitative research - 'too subjective', 'difficult to replicate', 'problems in generalisation' and 'lack of transparency'. Silverman (2000) also highlights problems in valid generalisation due to the use of small samples in qualitative research. Low reliability was highlighted by Berg and Lune (2011) as a shortcoming of qualitative research. They further state that qualitative research is a time consuming process and leads to weaker forms of measurement.

Precautions and appropriate actions were taken to deal with the criticisms mentioned above while designing and carrying out the research. Firstly, the semi-structured research tool was designed after an extensive literature review and consultation with the research supervisors. The research tool was used to collect data in a structured way. Secondly, a protocol for case study research was prepared which helped to replicate the research and collect the data in an organised manner. The findings of the research can be generalised in other health care set ups and other countries as the principles of health care are mostly universal in nature and they have common features in general. This study tried to make the whole data collection and analysis process very transparent. The interviews were recorded, transcribed and translated. The transcribed and translated copies of the interviews were sent to all participants for information, comments and factual corrections. Furthermore, the findings and recommendations of the research were sent to all participating hospitals. This study collected rich research data from health care professionals on their perceptions of interprofessional working, as they voluntarily participated in the research, in which they gave their time and expressed their opinions without any hesitation. Their knowledge, active participation and engagement were valuable and it was captured effectively through lively interviews.

There are different methods commonly used for collecting qualitative data, such as interviews, observations, case studies, focus group, documents and texts (Bryman and

Bell, 2011; Mason, 2002; Silverman, 2000; Saunders et al, 1997). In terms of the research objectives and questions of this study, case studies and semi-structured interviews remain appropriate choices, as in a health care setting the possibility of observation is very rare due to the confidentiality of service users and ethical issues. There remains very few documents and data in terms of clinical outcomes in hospitals in Nepal. Due to the extremely busy schedules of health care professionals and also hesitation to speak about their perceptions of interprofessional working in front of their colleagues and seniors, it was not possible to set up focus groups despite numerous attempts to conduct the focus group during the research in Nepalese hospitals.

4.3 Research Philosophy

The four aspects of research - ontology (the study of being or the nature of reality); epistemology (defines how we know what we know); methodology (concerned with the logic of enquiry) and method (the data collection techniques) are conceptually different, but interrelated. Epistemology is concerned with providing a philosophical basis for deciding what kind of knowledge is possible and to ensure that it is adequate and legitimate (Maynard, 1994). Ontological stance implies a particular epistemological stance and vice versa (Crotty, 1998). Methodology is the research strategy that connects the choice of particular methods to the research outcomes. Research methodology refers to systematically defining the research process, from the theoretical underpinning to the collection and analysis of the data (Collis and Hussey, 2003). It is understood as a scientific way and is a general approach adopted by researchers to investigate the research topic (Silverman, 2000). The methodological choice a researcher makes is determined by both philosophical assumptions about ontology and epistemology (Collis and Hussey, 2003; Gill and Johnson, 2002), and the research question (Collis and Hussey,

2003). This section mainly addresses the different philosophical assumptions on these dimensions: ontology and epistemology.

Research design is based on the conceptual framework, which influences the selection of an appropriate research method. The choice of research design and analytical tools, whether qualitative or quantitative measures, should be consistent with the philosophical and theoretical underpinnings of the study developed in the conceptual framework (Smyth, 2006). The use of qualitative and quantitative research is distinct as they are said to be based on different philosophical principles (Brannen, 2005). Many research scholars argue that research methods should fit into the context of the research question (Bryman and Bell, 2011; Mason, 2002). The framing of research questions may be underpinned by both philosophical and pragmatic issues (Brannen, 2005).

All research are based on research philosophy. The research philosophy and research politics are often dealt with independently in some literature of research methodology. Nevertheless, it is argued that these two things cannot be easily separated in research practice. As many researchers and scholars remind us, the research questions we examine and assess through research do not arise in a vacuum, but are built within systems of meaning, or models of reality. As stated by Gill and Johnson (2002):

> *'Social reality has a concrete existence independent from human consciousness and cognition, which is in many respects empirically indefinable and presumably measurable in some way'*
>
> (Gill & Johnson, 2002, p.128)

Social reality and actions of the actors are facilitated by their subjective process of attaching meaning to and interpreting reality. Therefore, explanations of social behaviour

reveal both the external material conditions that predict certain social actions, and the subjective human interpretation (Gill & Johnson, 2002). Burrell & Morgan (1979) states:

> *'The individual is seen as being born into and living within a social world which has a reality of its own'.*
>
> (Burrell & Morgan, 1979, p.4))

Collaborative practices within an interprofessional care team are affected by many internal, external and organisational factors and are influenced by many actors. Studying health care professionals in their everyday activities relies upon both theories derived from 'common sense' and 'social science research' (Gill & Johnson, 2002). Many research studies which are designed to investigate the acts and decisions of various actors and theory play an important role in the research design.

By emphasising the concepts of interprofessional care, this research focuses on the social processes, relationships and interprofessional care team dynamics between various health care professionals. This approach provides a solid foundation for the assessment and analysis of perceptions of roles and responsibilities, skills and competence, leadership, communication and interaction, professional identity, professional autonomy and professional boundaries.

Fieldworks at three hospital sites were carried out by employing an inductive research strategy focusing on process, meaning and understanding which has resulted in a rich descriptive product. In this sense, an inductive reasoning was used as described by Schriver (2001) which is about reasoning from specific observations to general principle or theories and the researcher starts from observed data and develops a generalisation which explains the relationship between the objects observed.

Qualitative research comes within the domain of interpretevist tradition, whereas quantitative research is by contrast associated with positivism. With regards to research epistemology, an interpretive research approach has been followed for this research as it focuses on enriching our understanding of human experience (Elliott, 1999). Schwandt (2001) describes that an interpretive approach provides an in-depth insight into the complex world of lived experiences from the point of view of those who live it. In this study, health care professionals are the real actors who work in a very complex health care environment and experience the impact and effect of team collaboration between various professionals in hospitals. Interpretive approach believes that reality is socially constructed and the researcher reveals this fact (Bryman and Bell, 2011; Mason 2002). During the interview process, interactions between health care professionals and the researcher construct the social world by gathering data through interaction, discussion and various means of communication. The researcher in this study was the key role player to interpret interviews carried out with health care professionals. This approach helps to bring such vague subjective information to reality and actuality, with solid arguments rather than statistical figures, facts and numbers.

In terms of research ontology, this study is placed within the constructivist paradigm. Constructivism recognises knowledge as socially constructed. According to Charmaz (2006), constructivism assumes that the actors or individuals construct the meaning of experiences and events. Health care professionals construct the realities in which they participate in this research. From this point of view, this study aims to recognise how health care professionals construct their individual and shared meanings around interprofessional working and phenomenon of interest.

Crotty (1998) defined constructivism as:

> *'the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context'* (Crotty, 1998, p.42).

The aim of qualitative research is to engage the researcher to probe deeper into understanding rather than examining surface features (Johnson, 1995) and constructivism may help to achieve this aim.

4.4 Research Design

The research design is probably one of the most vital factors in influencing the quality of research findings. Research design is influenced by many factors such as philosophical, social and pragmatic. Interestingly, not all of them are within the control of the researcher.

Quantitative and qualitative research approaches are based on different paradigms, and various distinctions between these two approaches are discussed in literature. Bryman (1988) states that qualitative approaches are based on *`rich, deep*' data and quantitative approaches are based on *'hard, reliable*' data (p.94). Furthermore, data is situated in personal accounts and constructions are contextual in the qualitative paradigm (Mason, 2002). This study aims to assess health care professionals' perceptions on interprofessional working. Personal accounts of health care professionals in this study are certainly deep and rich; and the constructions are contextual. In the absence of any previous research, lack of organisational and national policies on interprofessional working in Nepal and no solid base for collaborative team practices, it is almost impossible to collect the hard data in this field.

Quantitative research has its base in pure or natural sciences aiming at finding universally accepted truths that show a cause effect relationship; whereas qualitative research has evolved in social sciences aiming at understanding and interpreting behaviours in specific contests (Fischl et al, 2011). Hammick et al (2009) argue that interprofessional care teamwork depends on the team members working with a variety of shared values and principles; acknowledging and accommodating some differences; and it is based on communication and interaction. Therefore, interprofessional working is not a natural science and it has many ingredients of social sciences. Due to this reason, qualitative research approach for this study fits better within this concept.

Furthermore, quantitative research approaches are used to test a hypothesis or to test a set of pre-defined theories and ideas which are deductive in nature (Murphy et al, 1998), whereas qualitative research approaches are mainly used to explore social phenomena and to generate ideas and theories form the data and are inductive in nature (Denzin & Lincoln, 1998). Hospitals and health care professionals work within certain social, political, economic and legal boundaries. This research tries to explore understanding and perceptions of health care professionals on interprofessional working in their health care settings, rather than testing any hypotheses. In this context, qualitative research method is chosen for this research.

According to Bryman and Bell (2011), quantitative research approaches tend to claim a degree of objectivity, data is quantifiable and reduced to numbers. In contrast to this, qualitative research methodologies focus on the subjective nature of the data generated (Mason, 2002). Quantitative research uses an object related approach with the aim of explaining cause-effect relationships by testing the theories with empirical data produced by measuring, counting, or scaling (Mays and Pope 2000). Variables are measured with numbers, and analysed using statistical techniques in quantitative research. The aim of

quantitative research approach is to conclude whether predictive generalisations of a theory hold true. Quantitative research involves the use of methodological techniques that represent human experience in quantitative or numerical categories, sometimes referred to as statistics (Marvasti, 2004). Laurenson (2007) describes that quantitative research is assumed to be more scientifically based than qualitative research. If the argument to support this is that such research findings are seen as more valid and reliable, then it leaves many unanswered questions about human nature.

One of the objectives of this study is to identify and analyse various factors that support and hinder interprofessional working in Nepalese hospitals and to make recommendations for improving interprofessional working practices. It is more sensible, logical and practical to capture experiences and perceptions of health care professionals rather that quantify these factors associated with interprofessional working. Furthermore, there are no standard approaches practised in Nepal to measure the impact of interprofessional working on the delivery of health care and clinical outcome. Hence, the qualitative approach is chosen and the subjective nature of data is collected to capture experiences and perceptions of health care professionals on interprofessional working. Furthermore, Fitzpatrick et al (1994) suggest that qualitative research methods are suitable when researchers are focused with identification and conceptualisation of issues.

This study is mainly focused on assessing participants' own experiences and understanding of the subject they are involved in or have experienced. Therefore, the qualitative approach is considered a more appropriate approach. This is supported by many research authors and scholars. For instance, Saunders et al (1997) suggest that the non-standardised and complex nature of qualitative data should be classified into categories before it can be meaningfully analysed. Similarly, Kvale (1996) describes qualitative research analysis as more inductive and categories emerge out of the data

rather than being imposed before the data collection. Kvale further mentions that qualitative methods aim to identify the views from the perceptions of the participants, to clarify the meaning of experiences of the respondents and to reveal their lived world rather than scientific basis and expectations. Moreover, Cupchik (2001) claims that qualitative methods offer an in-depth account of underlying processes and can test specific functional relationships between actors. Mason (2002) supports the idea and explains that human behaviours are not ruled by general or universal laws that are characterised by underlying regularities. In line with the logic above, Bryman and Bell (2011) describe that qualitative research deals with the words, and theory is generated out of the research in qualitative approach. The researcher is the principal data collection instrument in this study as it is the usual case in qualitative research (Silverman, 2000) and it is tries to understand the phenomena and to interpret the social reality from different perspectives.

Qualitative research is a broad term. Silverman (2000) discusses the problems in defining what qualitative research is and mentions that there is no '*agreed doctrine underlying qualitative research'* (Silverman, 2000, p.38). He describes various models within the field, and suggests a number of preferences of a qualitative researcher such as naturally occurring data; understanding meanings; analysis of words and images; and hypothesis generating research. These preferences are also considered and are strongly supported for choosing this study design.

The following points as described by Elliott (1999) also support the choice of qualitative research approach for this research:

- emphasis on understanding phenomena in their own right as this research aims to assess health care professionals' perceptions of interprofessional working on

health care delivery (vs. looking from outside perspectives and world in quantitative research);

- open and exploratory research questions as this research is carried out by using semi structured open interview questions is (vs. closed-ended hypotheses in qualitative research);
- unlimited, emergent description options as this research explores various factors that support and hinder interprofessional working between various professionals (vs. predetermined choices or rating scales in qualitative research);
- definition of success conditions in terms of discovering something new as this research aims to make recommendations for improving interprofessional working practices (vs. confirming what was hypothesised in quantitative research).

4.4.1 Case Study

Yin (2003) defines case study research as '*an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident*' (p.13). Wilson et al (2000) define case study research as 'the in depth analysis of a single or small number of units such as a person, an organisation or an institution', fulfilling a main condition for this research to provide in depth data (p.61). According to Leedy (1997), case study is the 'fact' of any particular research issue, the contents of which require an in depth study of the social science issue to realise its phenomenon on the basis of it being an individual problem. Yin (2009) suggests that case study methods often answer the 'why' and 'how' questions, which is exactly why this study has decided to adopt the case study as the research questions are 'how do various health care professionals interact and collaborate in hospitals' and 'how do they perceive the impact of interprofessional working within

teams on the delivery of health care'. Furthermore, interprofessional working is a relatively new concept for Nepal and there is no research literature published or available on this topic in Nepal. In this context, Gill and Johnson (2002) raised a valid point as stated below, which further supports the choice to adopt the case study method for this study:

> *'Case study research may perhaps be most appropriate when little is known about a topic and where in consequence there can be little reliance on the literature or previous empirical evidence. Such approach may also be most useful in the early stages of research ... '.* (Gill & Johnson, 2002, p.119).

According to Yin (2009), the case study approach can be either a single case or multiple cases. The former stands on its own, whereas the latter enables the researcher to make comparative and different levels of analyses from various perspectives. Yin further emphasises the importance of the selection of cases in case study research. This research sought to examine interprofessional working between health care professionals in Nepal. Therefore, this study has selected one case from each of the public, private and not-for-profit category of hospitals in Nepal to represent all types of hospitals. The next step was to define the unit of analysis. As suggested by Yin (2009), each group of health care professionals was considered as a single sub unit of analysis under a holistic multiple case study design. The decision to use a multiple case design consisting of three groups of health care professionals is discussed later in relation to sampling and methodological rigour. The multiple case study design contributes to a deeper understanding and explanation of the research problem as discussed in the earlier section.

Health is universal and there are established practices and norms in clinical care or health care around the world. The nature of this research in a case study format, and the health care professionals being researched, gave the opportunity for results to be considered

reproducible. This study is classical and an example in the way that health care professionals collaborate in an interprofessional care team in developing nations. Therefore, this research is likely to have an especial learning value.

4.4.2 Research Tools

Berg (2004) states the starting point for the construction of an interview schedule is the aims, objectives and nature of the research or investigation. He suggests reading of the literature to develop general relevant areas, followed by the generation of lists of questions for each of the categories. This was the method employed for this study to develop semi structured research questions. At the initial stage, an extensive literature was carried out to identify key categories and sub-categories of interprofessional working. Based on the literature review, the semi structured interview schedule was then developed from these main categories.

Semi structured individual interviews were carried out with selected members of nursing, medical and allied health professionals. The benefit of using the semi structured interview is that it is flexible and questions that are not included in the interview schedule can be asked (Bryman and Bell, 2011). Pope and Mays (2000) support this flexible approach of interview and suggest that interviewers should be familiar with the topic being discussed with the interviewee. A semi structured interview gives freedom and opportunities to explore many unidentified or hidden areas that may be raised by the interviewee during the interview process and can be followed up at the time. Discussion and interaction between participants and researcher during the interview helps to stimulate sharing of more information. Furthermore, in-depth knowledge and sharing perceptions of health care professionals were gained through interviews in this study, which may not have been possible by using a questionnaire. Saunders et al (1997) argue that interviews develop a two-way relationship between respondents and the researcher which helps to share the

meaning of experience and also allows the researcher to collect narrative facts to extend the understanding of the human phenomena under study. Silverman (2000) discusses various methods of data collection (e.g. observation, interviews, textual and documentary analysis) in qualitative research and believes interview data is more reliable than that of observational and documentary data. He further describes that analytical techniques for interview data provide reliability, and challenges tendencies towards relativism, seeing the need to 'sort fact from fancy' for analyses to be taken more seriously. Bryman and Bell (2011) state that due to the flexibility of the interview, it is probably 'the most widely employed method' of qualitative research.

Pope and Mays (2000) suggest that interviews are less structured and are useful to qualitative research because they are more flexible, iterative and continuous. Berg and Lune (2011) argue that participants are interviewed in greater detail for the results to be taken as true and correct. The qualitative approach with semi structured interviews with three groups of health care professionals (medical, nursing and allied health professionals) was followed in order to secure a greater understanding of how they collaborate in an interprofessional care team to deliver health services. Because of the nature of the open ended questions, they cover different perspectives and have a greater scope.

The same semi structured research schedule and methods of data generation were used in the multiple case study design at each hospital site to allow comparison and contrast between data obtained from each location. The semi structured interview schedule was divided into two main sections - demographic section and question section. All together 16 themes were included in the main section for questions which were divided into four groups - firstly general view on interprofessional care and health care; secondly different roles at the work place and teamwork; thirdly professional identity, autonomy, power and

decision making; and finally triggers and barriers for interprofessional care. Each response was further explored with appropriate probes in order to encourage free discussion and the exploration of interviewees' perceptions and experience on interprofessional care (full details of the semi structured interview schedule can be seen in Appendix 6).

4.4.3 The Population of the Study

I spent more than fourteen years working in the health care management field in Nepal and I have a very good understanding of the hospital system in Nepal. I would like to contribute more to my native country in the future. Therefore, research on interprofessional working in Nepalese hospitals seems very sensible and appropriate in this context. Having a Nepalese background and knowing the language and culture has benefits in terms of carrying out the research and presenting it to the mass audience.

The 'health care professional' is a broad term which covers all professionals working in the health services. Based on the nature of their work, identity, professional registration requirements established norms and practices; the health care professionals are divided into three groups – medical, nursing and allied health professionals in this study. Allied health professionals include all professionals excluding medical and nursing professionals such as- physiotherapists, bio-medical scientists, pharmacists, radiographers, pathology technicians, language and speech therapists, occupational therapists, etc.

These three groups cover all clinical or health care professionals in the health care field. The reason for the breakdown of the three groups is that each group has their own field of established practice, education and training set ups and legislative route for registration with professional councils. The three professional groups described above are regulated by their own regulatory body or professional council in Nepal. Medical, nursing and

allied health care professionals must be registered respectively with Nepal Medical Council, Nepal Nursing Council and Nepal Health Professionals Council to practise legitimately in their field in Nepal.

4.4.4 Sampling Process

Sampling is a range of methods that enable a researcher to identify a portion of the population and to reduce the amount of data, instead of selecting the whole population for research (Saunders et al, 1997). Sampling can be categorised into two main types - probability and non-probability sampling. Probability sampling is the most commonly used method for the survey based quantitative research. There is a standard method and criterion for selection of samples and there is an equal chance of being included in the sample for every member of the population (Brymen and Bell, 2011). On the other hand, there is no standard method to the selection of samples in the non probability sampling. However, there could be a criteria for selection of samples. In this sense, the possibility of being included in the sample cannot be predicted in the non probability sampling (Silverman, 2000).

The sampling process for this study is non-probability and purposive sampling. The purposive sampling is widely used in qualitative research (Silverman, 2000; Mason, 2002; Patton 2002; Devers and Frankel, 2000) as it identifies cases of interest from people or organisations which are ‘information rich’ for the study and good interview or study subjects (Patton, 2002). It was intended to learn a lot from concerning issues of essential importance to the purpose of the research from information rich cases in this research. Therefore, it was decided that different health care professionals (medical, nursing and allied health professionals) in each hospital who work together and collaboratively in an interprofessional care team were chosen.

The main weakness of non probability sampling is the possible bias because the samples are self selected without using a standardised method (Robson, 2002); also the degree of generalisability is questionable (Bryman and Bell, 2011). This criticism can be partly relevant for this study as health care professionals and teams from various other hospitals were also eligible for inclusion in the research and could have been recruited. The researcher tried to reduce this bias to an extent by approaching a number of health care professionals in the selected hospitals and discussing their interest, team structures and dynamics. Although self selection of health care teams and health care professionals in this research can be viewed as a weakness, it can also be seen as an advantage as there is the chance that non probability purposive sampling may give higher response rates (Silverman, 2000), it is inexpensive and convenient (Berg, 2004). Mason (2002) argues that the need for familiarity with the sample could make it more relevant to use non probability sampling for in depth interviews. This approach of selection of non probability samples allowed for the selection of samples that fit the needs of this research.

Hospitals in Nepal are mainly divided into three types – public, private and voluntary. It was intended to select one hospital from each group to make the study more representative. Identifying and negotiating access to research sites, subjects and population are critical parts of the research process especially in qualitative research (Devers and Frankel, 2000). A list of hospitals in Kathmandu was prepared and compared their capacity, nature of work and year of establishment. One hospital from each group was selected for this study. All selected hospitals were contacted for formal approval in order to carry out the research. All three selected hospitals gave permission to conduct the research in their hospitals. The three hospitals selected for this study have common features, such as they were all established between 1994 –1997, and offer secondary care in Kathmandu, the capital city of Nepal. The inpatient capacity in each of these three

hospitals ranges from 100 – 150 beds. Therefore, the selection of these three hospitals is done with a specific purpose and objective in mind as mentioned above to assess the interprofessional working practices in Nepalese hospitals.

The questions are designed to draw upon health care professionals' experiences and perceptions of working with others in an interprofessional care team. The research aims to be as reflective as possible in order to look at the diversity of experiences in working collaboratively in Nepalese hospitals. Initially, few meetings were carried out with the hospital management and those in-charges of departments to determine the roles of the selected members of interprofessional care teams. A list of health care professionals and different interprofessional care teams working in the selected hospitals was obtained from the hospital management. Appropriate members of interprofessional care team in each hospital were selected to assess their interprofessional working and collaborative practices. The main selection criteria of the team was to have a wider representation of all three groups of health care professionals working together collaboratively in an interprofessional care team. Therefore, the selection of the team was purposive sampling. The purposive sampling enables the researcher to use judgement to select cases which best answer the research questions and to meet the research objectives (Saunders et al, 1997). Purposive sampling is an appropriate approach in this study as it allowed a selection of a specific hospital and a team of health care professionals who work in an interprofessional team and collaborate with others. Most sampling in qualitative research use purposive sampling of some kind and the researcher does not intend to sample research participants on a random basis (Bryman and Bell, 2011).

There were three inclusion criteria for all participants in the study. Firstly, all participants should be professionally qualified. Secondly, the participants should be registered with their professional councils and should be eligible to practise in their health care or clinical

field. Finally, all health care professionals should be working with an interprofessional care team.

The sampling for the interview was guided by the principles above and there was a target interview sample size of around 30 participants for this study, with an ideal sample of 10 participants from each of the three health care professional groups and hospitals. It was felt that this would allow engagement with a range of views from all professionals .There was a wide representation of health care professionals from different groups and roles such as hospital executive directors/chief executive officer, head of departments, team in-charges, doctors, nurses, pharmacists, public health officer, rehabilitation officer, laboratory technicians, radiographers and optometrists. A total of 38 interviewees participated from the three hospitals in Nepal. Of the total participants, 13 were medical professionals, 15 were nursing professionals and 10 were allied health professionals. Similarly, 13 participants were from a public hospital, 14 were from a private hospital and 11 were from a not-for-profit hospital or voluntary hospital.

The following table shows the sample size and the number of health care professionals working in each hospital:

Table 1: Number of Health Care Professionals and Sample Size in Each Hospital Nepal

	Medical		Nursing		Allied Health Professionals		Total	
Hospital	Number of Employee	Sample Size	Number of Employee	Sample Size	Number of Employee	Sample Size	Number of Employee	Sample Size
SGNHC	67	4	107	5	41	4	269	13
TIO	22	3	64	4	54	4	316	11
MNH	81	6	80	6	41	2	302	14

Note: Number of employees in each group includes part time and session basis health care professionals working in each hospital.

4.4.5 Reliability and Validity

Validity and reliability are two important factors to be considered by qualitative researchers while designing a study, analysing results and judging the quality of the study (Patton, 2002). Many researchers have used different terms to describe reliability and validity in qualitative research and distanced themselves from the quantitative approaches. Guba (1981) has described four criteria - credibility (in preference to internal validity); transferability (in preference to external validity/generalisability); dependability (in preference to reliability) and confirmability (in preference to objectivity) in qualitative paradigm which correspond to the criteria employed by the quantitative researcher. Furthermore, Lincoln and Guba (1985) describe credibility, neutrality, dependability, consistency, applicability and transferability as the essential criteria for quality in qualitative research. Reliability and validity are described as a means of testing trustworthiness, rigour and quality in qualitative research (Golafshani, 2003).

Reliability: Reliability checks the consistency of the research method. Bryman and Bell (2011) defines reliability as the consistency of a measure of a concept. The quality assurance measures were taken and maintained to record experience and perceptions of the participants about interprofessional working, to transcribe the recordings; and to code and analyse the information. Krippendorff (1980) suggests that reliability in content analysis can be maintained in three ways - a) stability - measures the extent that the same coder is consistent over time, b) inter-coder reliability - different coders produce the same results for the same content, c) accuracy - the extent to which the grouping or categorisation of text corresponds to a set criteria or standard. These principles were followed as suggested by Krippendorff during the coding for stability and reliability.

As suggested by Yin (2009), a case study protocol (Appendix 8) was prepared before the research commenced and carried out interviews to increase reliability for the research

process. The purpose in doing so *'is not to guarantee that a second researcher will arrive at exactly the same conclusions as the first one might have; the second researcher can use the same data and give a different interpretation based on her/his own beliefs and abilities to grasp the essence of the emotional context*' (Andrade, 2009; p.50).

Trustworthiness: As described by Golafshani (2003), examination of trustworthiness is very important to ensure reliability in qualitative research. It tried to maintain this by sharing the transcript, result and findings with participating health care professionals and hospitals in a transparent way to make it more reliable.

Dependability: Guba (1981) describes dependability in qualitative research in preference to reliability in quantitative research. In order to reinforce the dependability of the study, various tools such as a computer word processor were used to store and manage the data. The data were coded and analysis decisions were recorded through the use of various tools such as analytical memos, labels, descriptions of codes, initial grouping of codes and theme building. This was the point in which analysis process was checked and tracked. Furthermore, a reflective diary was maintained throughout the interview with health care professionals which certainly helped to maintain dependability. Shenton (2004) describes the need to focus on the process within the study in order to address the dependability issue more directly. As described earlier in this section, the 'Case Study Protocol' for this research as prepared, will enable a future researcher '*to repeat the work, if not necessarily to gain the same results'* (Shenton; p.71).

Validity: Validity refers to appropriateness of instrument in measuring what aims to measure. In this research, it was tried to maintain validity by structuring the research tool and interview schedule in a way that is appropriate and valid to measure their experiences and perceptions of interprofessional working. The research tool was designed after carrying out extensive literature review in the field of interprofessional working and

many discussions with research supervisors in order to make sure that the tool is fit for purpose and can measure what is intended to measure. Moreover, the tool was piloted in two stages as described below in section 4.5 to ensure feasibility and validity of the research tool. Verification of participants was done by checking the eligibility criteria of the participants before commencing the interview to ensure an appropriate health care professional is included and to check the validity in this research. Yin (2009) cited explanation building, pattern matching, addressing rival explanations and using logic models as methods for improving internal validity. In line with this, a full explanation about the research was given and participants were given opportunities to ask questions before the interviews started. The participants were asked supplementary questions during the interviews and they had a chance to ask questions and make clarifications during the interviews. In addition, they had enough time to think about their responses and answers. Moreover, a multiple case study approach was used in this study by carrying it out in three hospitals or cases. This is '*a common strategy for enhancing the external validity*' or generalability of research findings (Merraim, 1998; p.49). According to Miles and Huberman (1994) multiple case study also 'strengthens the precision, the validity, and the stability of the findings' (Miles and Huberman, 1994; p.29).

Apart from the interviews with health care professionals, protocols, procedures and policies for interprofessional working and team work were reviewed. In this way, multiple evidence and sources of data were used in this research. Denzin and Linclon (2000) argue that using multiple sources of evidence improves the probability of accepting the interpretation of information and findings and presents support for all aspects of data collection. All interviews were recorded in digital format and were transcribed and translated into the English language. Transcribed and translated copies of the interviews were sent to all participants to check for factual corrections and comments.

Few of the participants sent back their comments and corrected their copy of the interviews. Many of them said they were happy with the translated and transcribed copies of the interviews. In this way, validity of the interviews was maintained to ensure that actual statements were recorded and analysed for the research. Saunders et al (1997) argue that internal validity deals with the extent to which a description accurately represents the social phenomena it claims to represent. However, Pope and Mays (2000) believe that the qualitative researcher is primarily interested with insight and perceptions rather than truth per se, as reality is viewed as multi-factorial and ever-changing. Internal validity establishes causal relationship as distinguished from spurious relationships and pattern matching is one of the criteria by which the researcher compares an observed pattern against a predicted one for internal validity (Yin, 2009).

Credibility: Guba (1981) describes credibility in qualitative research in preference to internal validity in quantitative research. One of the methods of ensuring credibility in qualitative research is to apply well established methods (Shenton, 2004). A case study approach was applied to carry out the research. The adoption of research methods that are '*well established both in qualitative investigation in general and in information science in particular*' promotes confidence that the qualitative researcher has accurately recorded the phenomenon (Shenton, 2004, p.64). Yin further confirms the importance of adopting an appropriate operational measure for the concepts being studied to promote validity in case study approach (Yin, 2009).

Secondly, the well described method of maintaining credibility in qualitative research is the use of multiple data sources (Bryman and Bell, 2011; Mason, 2002; Berg 2004; and Shenton, 2004) to provide a holistic and contextual context. As mentioned earlier, different sources of data such as interviews, job descriptions, hospital strategies and organisational structures were used for this study.

Thirdly, Shenton (2004) describes another way of promoting credibility in qualitative method is to apply a tactic which helps to ensure honesty in interviewees or informants when contributing data to the research. Shenton further states multiple ways to increase credibility, each person approached for the interview should be given a chance to refuse participation; researcher to establish a rapport with participants and researcher to focus on his or her independent status; and opportunities to participants to withdraw from the research at any point. In line with these approaches, all participants were encouraged to be open and transparent from the beginning of each interview and aimed to establish a rapport and create an open environment. All the selected health care professionals were briefed who were approached for the interview that they had a chance to refuse to participate in the interview *'to ensure that the data collection sessions involve only those who are genuinely willing to take part and prepared to offer data freely*' (Shenton, 2004, p.66). Almost a quarter of the health care professionals who were approached for the interviews refused to participate. Furthermore, all health care professionals who were approached for the interviews and were interviewed were briefed that the researcher was doing this research as an independent researcher without any association with the hospital/s so that they can freely express their opinions or ideas and share their perceptions about interprofessional working without the fear of being treated unfairly and *'losing credibility*' (Shenton, 2004; p.67) in the eyes of the hospital management.

Fourthly, the credibility of the research is strengthened during the analysis of interview data by checking confirmatory or refuting evidence (Silverman, 2001). During this process, initial ideas and thematic frameworks were checked to examine the consistency by comparing three cases and different interview data. The interview data analysis was carried under the supervision and guidance of the supervisory team, main themes and findings were presented to the supervisory panels for discussion and consideration.

Transferability: Guba (1981) describes transferability in qualitative research in preference to external validity or generalisability in quantitative research. External validity is related to generalising research findings to other settings, times or samples. As described in the section above in research philosophy, the research comes under the interpretivist paradigm and the study is a construction between the researcher, the participants and the research field. Therefore, it can be stated that the generalisability or transferability of the research is limited. However, it is expected that the research can be generalised and replicated in areas of interprofessional working in other hospitals in many countries aorund the world. It is possible that the study can be transferred to similar situations in health care professionals' own practice setting with various health care teams.

Bryman and Bell (2011) state that purposive sampling is an approach to enhance transferability. According to Berg (2004), purposive sampling is mainly concerned with maximising the scope of research, seeking out typical and deviant cases. This was addressed during the research by selecting three different types of hospitals - public, private and not-for-profit (or voluntary hospital) and three different groups of health care professionals so that wide ranging perspectives can be heard.

4.4.6 Data Collection

Stake (2006) and Yin (2009) highlight the need of establishing a theoretical framework that structures data collection in a case study research. Yin (2009) also focuses on developing a protocol for a case study that contains the research instrument and procedures for data collection from each case and primary sources and general rules to be followed in using the protocol. Yin also suggests that the case study protocol is *'a major way of increasing the reliability of a case study*' (Yin, 2009; p.79). In this research, a case study protocol (see Appendix 8) was developed before data collection and research

commenced to facilitate the logistical planning and management around the data collection. Because of the exploratory nature of this case study, Stake's suggestion was followed to outline the main issues of the phenomenon under investigation that highlight the complexity and contextuality of the research aims and objectives (Stake, 2006).

The questions on the semi structured interview schedule were designed to draw upon health care professionals' experiences and perceptions of working with others in an interprofessional care team. The research aimed to be as reflective as possible in order to look at the diversity of experiences in working collaboratively in Nepalese hospitals.

All interviews were conducted in the hospital at the time and date of their choice. The duration of each interview varied. The duration of each interview was between approximately 45 minutes to an hour. From the personal experience of the researcher in this study, the length of interview did not always bear a direct relationship to the volume and quality of information collected. All interviews were recorded in a digital format with the informed and written consent of the participants. The interviews were transcribed, saved in the digital format and were anonymised to protect the confidentiality. The researcher's ethnic Nepali background and linguistic ability were a great help in the interview process and empirical work. This helped to shorten the time required in each interview and for the conversation to flow in a natural way.

All interviews were recorded successfully in a digital recorder and saved in the encrypted form. In terms of the reliability of the recorded interviews with health care professionals, Perakyla (1997) describes that tapes and transcripts eliminate many problems associated with accuracy, and therefore increases reliability. Bryman and Bell (2011) advise that audio recording gives plenty of time for the interviewer to concentrate on the interview process and responses. Furthermore, audio recording can make the participants or interviewees feel that their views are being taken seriously (Berg 2004). On the other

hand, transcribing of audio recordings is time consuming. However, audio recordings provide complete statements for verbatim information and tone of voice, which is very difficult by conducting an interview or observation notes.

The interview process was dynamic. The initial thoughts of health care professionals tangled with the researcher's own thoughts and meant that areas the researcher wished to raise, or seek clarity on, came to the fore. Once the interviews were recorded on tape, transcribed and translated, qualitative analysis of the interviews was started and analytical frameworks were developed. This journey went further in the process of the writing. In this sense, the process from initial interview to analysis and final writing involved a multi-level of perceptions.

4.4.7 Reflexivity and My Role as a Researcher

Reflexivity deals with role identification of the key role of the researcher for the construction of knowledge and it involves '*critical self-scrutiny*' which goes beyond '*the straight-forward interpretation*' (Khalid, 2009; p.84). Reflexivity is one of the important factors in qualitative research as the researcher is the primary actor and instrument of data collection and analysis (Stake, 1995; Merriam, 1998). According to Malterud (2001), '*personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research*' (p.485)

I was aware of my status, currently working as a senior manager with the National Health Service (NHS) in the United Kingdom and as a senior manager in Nepal almost a decade ago, may have an impact on the way health care professionals might respond or disclose their answers. My two books – '*Principles of Hospital Management*' and '*A Handbook of Accounting and Financial Management for Health Care Managers*' were published in

Nepal in 2005. These books are widely available and read amongst hospital and health care management students, health care professionals and hospital managers in Nepal. I also worked as an Associate Professor of Health Care Management in Nepal for four years and published articles regularly on contemporary health management issues in Nepal in national papers and various journals. Therefore, many health care professionals and managers know me as an academic in Nepal. I tried my best to introduce myself as an academic, rather than a hospital manager. Therefore, I introduced myself as a researcher from the University of Greenwich and did not disclose my current and my past employment status. I also mentioned to the participants that the research was carried out because I was passionate about the research and I was interested in the topic. In this context, I behaved like a research student and the participants regarded me as such. During the interview, no participants enquired about my previous background, interest or experience.

I was cautious of my wish to justify my own experience and I could not permit an emotional attachment to '*preclude the open, exploratory learner's attitude that is necessary for good data collection and analysis*' (Glesne and Peshkin, 1992; p.14). One of the reasons of choosing this research topic was my interest, experience and knowledge on the research subject. Therefore, my personal experience as a health care manager for over two decades is a positive point in understanding the insight of the research subject. My experience in management of health services helped me to enhance the understanding of the subject matter. It was one of the reasons that I was able to counteract, cross examine responses and ask supplementary questions in many instances. Furthermore, I was also able to put a limit on myself within the research subject during the data collection process. To build up a lively and open conversation; and a good rapport with participants, it was important that respondents felt confident in me, in terms of my skills

and knowledge on the subject matter and the interview process. My own experience cannot be separated from the research and reflexivity does not allow itself to be separated from the researcher's experience (Pollner, 1991). Various research scholars (Darra, 2008; Goodrum and Keys, 2007; Perry et al, 2004) mention that research participants feel confident, comfortable and keen to talk about their experiences if they feel that the researcher is knowledgeable and familiar with the research subject. This may help to aid research participants to disclose more information (Merriam, 2008).

I was born and brought up in a small village in Nepal. I spent almost fourteen years in health care and hospital management in Nepal. I returned to Nepal to conduct the research and fieldwork. In one sense it was like returning 'home' and I found it very easy to conduct the research in Nepal being a native Nepalese. There was no language barrier for me. Most of the participants preferred to speak in Nepali language as thirty five interviews (out of thirty eight) were in Nepali language. It was certainly a very positive experience for me and participants. Furthermore, being a native I found it very easy to build rapport and to create a conducive environment for interviews. It was also easier for me to understand and interpret tone, speed, facial expressions and language of participants during the interviews.

Many research scholars (Byrman and Bell, 2011; Ying, 2009; Watt, 2007; Mauthner and Doucet, 2003) have described the benefits of keeping notes; and maintaining a reflective diary for qualitative research. McGhee et al (2007) suggest that note, memo taking and journal keeping are effective ways of maintaining reflexivity. Firstly, I experienced the importance of a reflective diary and writing during my pilot study for this research which was carried out in an acute hospital in London. I continuously maintained the reflective diary and writing for the whole of my research. Although all interviews were recorded in a digital format, I maintained memos during the interviews. This helped me to think

carefully about the phenomenon under study, my assumptions, my own sense and behaviour that might have impacted the research. Furthermore, it became one of the vital tools for understanding reflexivity and overall aspects of research methodology.

All interviews were conducted at their work place. I booked quiet rooms and a meeting place for some interviews. Due to health care professionals' commitment at work and busy schedule, some interviews were carried out at their work place, such as at their clinic and investigation rooms. During the interviews, there were some interruptions. Some of the participants had to receive phone calls and meet patients, families or colleagues during the interviews. These interruptions and my physical presence did not make any difference to carrying out the interview and generating data and knowledge. I felt that all interviews were lively, informative, exploratory, and conversational with open ended semi structured questions.

Once the interviews were transcribed and translated, I accumulated a huge volume of data and information including interview memos and transcripts. All transcribed data were then compiled in two separate files and grouped by the type of hospitals and professional groups. All data were stored in a digital format in 'Word' version and hard copies were also printed and available for data coding, grouping and analysis. In the meantime, I continued reading literature and research methodology. According to Watt (2007), reflective interactions with data and literature, influence the decision making process during the qualitative research.

Data analysis processes are influenced by researcher's personal, interpersonal and emotional factors and other factors such as institutional and pragmatic influences (Mauthner and Doucet, 2003). Therefore, I was aware that my experiences, background and bias can influence perceptions and data analysis. Bolam et al (2003) argue that researchers are not separate beings rather they are part of the social world, hence their

roles need to be scrutinised. In qualitative research, it is really important to understand the researcher's view of the research subject and the role of researchers (Khalid, 2009) because the researchers interpret, define and understand phenomena in terms of the meanings of the research subjects (Lincoln and Denzin, 2000). Therefore, I focused on the research subject and I had the detail and thorough understanding of the research subjects.

4.4.8 Data Analysis

Data collection and analysis are two different steps but related to each other in a cyclical process. Although preliminary data collection began on initial contact with the hospitals, the more formal and rigorous data collection and analysis commenced with formal interviews with health care professionals to assess their perceptions and experiences on interprofessional working. From the interviews a number of issues and questions arose that informed subsequent gathering and analysis of the data from the three groups of health care professionals.

A multiple or collective case study approach was used as described by Baxter and Jack (2008) in this research as this allowed analysis within each setting and also across settings. Furthermore, three cases (hospitals) and three groups of health care professionals were examined to assess how they collaborate and to analyse their perceptions of interprofessional working on health care delivery so that '*similarities and differences between the cases*' (Baxter and Jack, 2008; p.550) and between different health care professionals were examined. Merriam (1998) says:

> *The more cases included in a study, and the greater the variation across the cases, the more compelling an interpretation is likely to be. ... while some case*

studies are purely descriptive, many more are a combination of description and interpretation or description and evaluation.

(Merraim, 1998; p.40)

Qualitative content analysis is considered as an appropriate approach in this research which goes further than counting words. It helped to understand perceptions of health care professionals on interprofessional working in a subjective but scientific manner. Content analysis is a qualitative research analysis approach to code qualitative information into systematic and predefined categories in order to analyse information, so that certain patterns or themes can be examined and established. It identifies certain patterns, so data and information can be analysed and reported through a systematic, objective and reliable analysis (Krippendorf, 1980). Saunders et al (1997) note that content analysis is capable of linking and establishing relationships between various variables otherwise hard to identify, allowing for tests of validity. Bryman and Bell (2011) defines content analysis as 'an approach to the analysis of documents and texts (which may be printed or visual) that seeks to quantify content in terms of predetermined categories and in a systematic and replicable manner'.

Polit and Hungler (1999) describe content analysis as a 'process of organising and integrating narrative, qualitative information according to emerging themes and concepts; classically, a procedure for analysing written or verbal communications in a systematic and objective fashion, typically with the goal of quantitatively measuring variables'. Content analysis is a method to analyse documents systematically and objectively, which makes it possible to describe a phenomenon in an abstract and conceptual form (Utriainen and Kynga, 2009).

Content analysis is used in this research to analyse the content of the interviews with health care professionals in order to find themes or patterns. The data analysis process begins with the data collection process. The early involvement helps to carefully examine and move back and forth between concept development, data collection and description and interpretation (Merriam, 1998) which could be more useful for addressing the research questions (Miles and Huberman, 1994). Elo and Kyngas (2008) suggest that the content analysis method in research may be used with either qualitative or quantitative data and in both ways - inductive or deductive. An inductive approach was followed by grounding the assessment of categories, patterns and themes; and by drawing inferences in the data. This gave descriptions and expressions from the interviews, which reflected how health care professionals view interprofessional working. This is an inductive reasoning process, as it examined and compared themes, patterns and categories that emerge from the interview transcripts.

Furthermore, an interpretive thematic approach was used to analyse the interview data as proposed by Seale (2004). Seale describes the approach of qualitative data analysis to be based on the key principles of open coding, categorisation and theme generation. This approach is consistent with the overall methodology. Therefore, it is considered to be the right approach of data analysis. It was more focused on interpretation and it allowed participating health care professionals to share multiple perspectives, so their own perceptions can be heard, examined and analysed. According to Seale (2004), this approach also provides a systematic, step by step method of analysing data. A combination of paper, post-it divider, highlighters and coloured markers was used to mark hard copies of transcripts to analyse interview data. This includes highlighting and coding words, sentences or paragraphs; arranging them into themes and categories; cutting up transcripts and pasting them in different folders created for different

categories; using a card index system for each theme; and using a computer word processor to support data handling and analysis.

As described above, electronic coding was also used on the soft copy of word documents. Initially, the use of pen and paper can be useful for small amounts of data. As the data grew, the electronic process was most useful and reliable, as it was a more practical choice. The initial data analysis process for interview data involved reading each transcript line by line and generating a code to ensure all information, data and statements are carefully considered and reflected on.

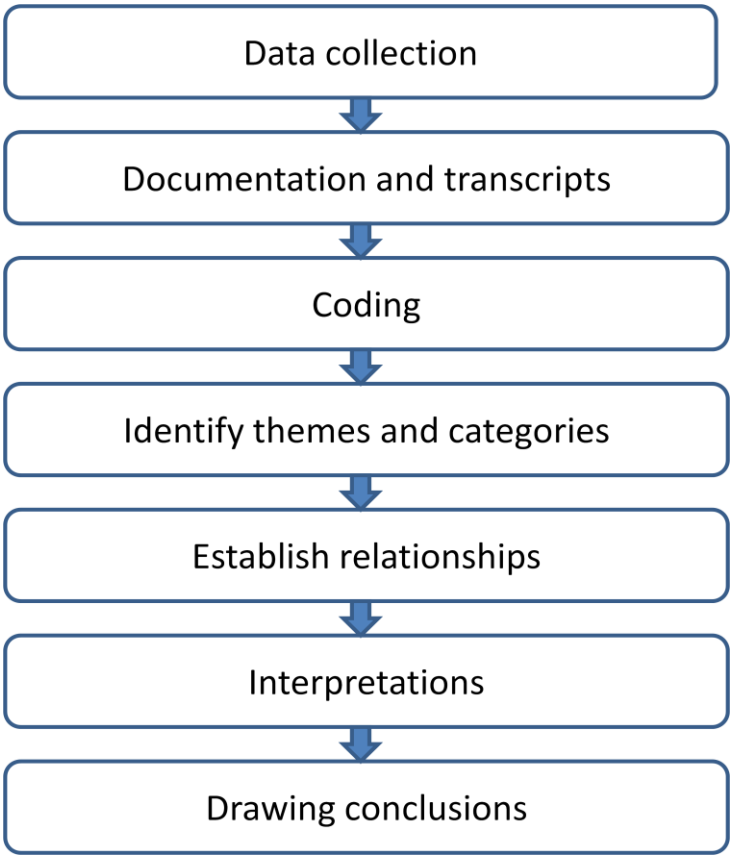
The coding of interview transcripts includes generating different themes and patterns. This process may help to generate various codes based on the research objectives and questions. This was the initial open coding process of the interview data. After the initial open coding process, the second stage was to reduce the data further, by carrying out more detailed and selective coding. During this process, transcripts were read and re-read and the codes generated at the first stage. Similarities and differences were looked at until themes and categories were developed. The data reduction process continued until a logical argument was established and adequate exploration of research objectives and questions were provided. The data was linked with various codes and themes. It was reflected on the themes within and between the three cases and three professional groups studied to examine similarities and inconsistencies by exploring research objectives and questions. The themes gave a clear pattern of overall experiences and its nature, the structure and manifestations of the experience, and recurrence of the experience of health care professionals.

A computer was used to store data and a word processor was used to analyse data which facilitated assign, delete and re-assign codes easily. In the meantime, transcripts were printed and notes were made manually as described above. Therefore, the data analysis

process for the interview data was combined by using the computer and the interpretive thematic approach as stated above.

The following figure summarises the data analysis process in this research.

Figure 2: Data Analysis Process



Department and hospital reports, hospital strategies, job descriptions and hospital policies were analysed in order to carry out the research.

4.5 Pilot Study

Berg and Lune (2011) state that the beginning point for developing a research interview schedule is based on the aims of the research and the nature of the research question. They suggest the use of literature review to develop general ideas on the relevant areas followed by the development of research questions for each of the categories. This idea was followed for this pilot study and read the relevant literature on interprofessional care

and collaborative practices between health care professionals which helped to develop key themes and areas on interprofessional working.

The pilot study aimed to help redesign the study by taking corrective measures prior to the commencement of the main study at the later stage. Bryman and Bell (2011) suggest the use of a pilot study in interview methods and highlight the importance of conducting the pilot study to test how effectively it works, to determine the adequacy of instruments to interviewers, to see how well the questions flow and whether it is necessary to move some of them around to improve the research tool (pp.262-263). The main objectives of the pilot study were as follows:

- To gain a real insight and experience of carrying out an interview for the research
- To test the reliability, validity and feasibility of the research tool and to refine the research tool as required
- To be familiar with research procedures such as recording, coding, transcribing and data analysis

The first pilot study for this research was carried out by using a questionnaire and a semi-structured research schedule in an acute hospital in London in March 2012. The pilot study was carried out with three different health care professionals – medical, nursing and allied health care professional (therapist) who work together as an interprofessional care team. One respondent or participant from each group was selected to be interviewed by using a semi-structured interview schedule and questionnaire. All participants were professionally qualified and were registered with the respective professional councils. Participation was on a voluntary basis and verbal consent was asked for the administration of the questionnaire and interviews. The questionnaire was handed over to

the health care professionals working in an interprofessional care team in the acute hospital. The interviews were carried out at their workplace.

After the interview, a short discussion was held with all participants on an individual basis to record the experience of the process, with a view to modifying the process and tools for future use. Alterations were suggested for some questions for better flow and consistency. For example, respondents were not clear about the questions for professional autonomy and identity. One respondent struggled to define her professional roles and suggested altering this as professional responsibilities and experience of health care professionals. Another respondent suggested merging two questions for professional boundaries and barriers. There were some suggestions made to reword questions. Appropriate wording and flow for all questions were also discussed with all participants. These suggestions were considered and necessary modifications were made when devising a modified research tool for the main study at the later stage.

The semi-structured interview schedule was piloted in a hospital at the beginning of the research in Nepal to test the suitability of the research tool in the Nepalese health care context. The participants were happy with the tool and the content of the semi-structured questions. However, there was a suggestion to translate the tool into the Nepali language and use it as a reference document whilst interviewing health care professionals in Nepalese hospitals. There was also a suggestion made to not use acronyms and to merge three questions related to professional identity, autonomy and boundaries together. As a result, the semi-structured research tool was translated into the Nepali language (Appendix 7) and no acronyms were used in the research tool. The questions were related to three different, but inter-related concepts, 'professional identity', 'professional autonomy' and 'professional boundary' were linked to each other and a new sequence of questions was formulated as a consequence of the findings of the pilot study. The health

care professionals who participated in this pilot study were excluded from the final research study.

4.6 Ethical Considerations

Ethical approval is essential to carry out research to protect both parties – participants and researchers. On one hand, it protects rights, welfare, safety and dignity of participants and on the other, it also defends the researcher's rights to carry out legitimate research. Moreover, it safeguards the University of Greenwich's reputation for research conducted and sponsored. Therefore, ethical approval is linked with maintaining quality in research.

The first point to consider before deciding the research proposal, design and ethical consideration is to make sure the research is beneficial and worthwhile, in terms of time and resources for the researcher and the organisation involved. After a long discussion and a review of the research design at different levels, and feedback from organisations and participants involved, it is expected and agreed that the research findings would be beneficial for health care professionals who devoted their time to making the research a success.

Another way to ensure that the research is worthwhile is through approval from supervisors and institutional research committees. Ethical approvals were obtained from three levels to carry out the research. Firstly, the University Research Ethics Committee at the University of Greenwich approved the research design and approved the application for ethical considerations. Secondly, formal approval from three hospitals in Nepal, where the study was carried out, were obtained. Finally, the Nepal Health Research Council (a national regulatory body to oversee and regulate health research in Nepal) approved the research after an extensive review of an application for the ethical clearance (please see Appendix 3). The Nepal Health Research Council published

'*National Ethical Guidelines for Health Research and Standard Operating Procedures*' in 2011 to strengthen public confidence in research and improve the quality of research activities and projects in Nepal. The guidelines and protocols relate to four key principles and domains - respect for the autonomy of the participant, beneficence and non-malfeasance, justice and respect for the environment. The researcher was familiar with the guidelines and standard operating procedures and adhered to its key principles.

The obligation to respect the dignity of participating individuals in all activities of health care research is the cornerstone of research ethics and the principle is based on the premise that an individual participant when informed of all aspects of an activity can decide a correct course of action (NHRC, 2011). There is a consensus that the researcher has to give due consideration to dignity, autonomy, rights and well being of participants (Bryman & Bell, 2011; and Robson, 2002) which includes obtaining formal and informed consent from participants, assuring anonymity and confidentiality and an assurance that there would be no professional or personal consequences as a result of participating in the study.

Before the interview, each participant received a Research Information Sheet (Appendix 4). Therefore, they were fully informed of the research aims, potential benefits and consequences and were asked to give consent voluntarily. Participants were briefed at the start of the research, they had the right to withdraw from the research study without prejudice and without impact on their care. Confidentiality and anonymity of research participants are preserved by coding data. Each participant was asked to sign a written Consent Form (Appendix 5). Informed and written consents were obtained before starting the interview or entering into a research project.

The interviews with health care professionals were held at their workplace. Service in-charge and Chief Executive Officer or Executive Directors were informed of the

interview. Meeting rooms and quiet departmental offices were booked for the interviews. The interviews were held in a quiet environment without any distractions. Interviews with health care professionals were recorded with a digital audio recorder. Formal consents were obtained to record the interviews. All recordings were coded and saved in an encrypted digital device to maintain confidentiality and anonymity of the research.

Audio recordings of interviews were coded to ensure that the participants' details do not appear on the recording, or on the box. Interviews were transcribed as soon as was practical by using the code. Original digital recordings will be destroyed once the research is completed by using appropriate software to shred and destroy digital data or recordings from the computer. In the interim period, the recording equipment is stored in a locked compartment. Transcripts are held in an encrypted memory stick or in a password protected computer or equipment, to which only the primary researcher has access. The key to the identity of participants is stored in a different part of the system, to avoid accidental disclosure of participants' identities. Information is not passed on without the knowledge or consent of the participants. Quotations used in the text of the research are anonymised, although the participants' broad area of practice and professional background may be identified if it is essential to understand the issue under discussion. Research participants were offered copies of a transcript of their interview. They will be informed of the dissemination of the research findings following completion.

4.7 Summary

In this chapter, the research philosophy and methodological framework within which the research can be situated were outlined. The research tools used for this research, population of the study, sampling strategy, and data analysis methods applied for this study are also explained in this chapter. The rationale for the chosen research approach

and a detailed review of the theoretical and practical implications of research methods are also detailed in this chapter.

Furthermore, a brief synopsis about the pilot study that was carried out before the main research was discussed in this chapter. This chapter also explained and addressed some of the concerns that are often associated with qualitative research, including its reliability and validity as well as the strategy to deal with those concerns. Finally, this chapter also outlined ethical issues encountered during the research process and the way it was dealt with.

Chapter 5: Health Care and Education System in Nepal

5.1 Introduction

Every health care system is different and every health care organisation is unique in terms of its objectives, structures, priorities, resources, processes and outcomes. Overall structure of health care delivery system and the level of integration and collaboration between different health care professionals can be examined in the wider context of national health care and educational policies, priorities, and organisational influence and structures. Different health care organisations have different levels of organisational complexity around management, types of administrative bodies, governance, and infrastructure support (CHSRF, 2006). Different factors, such as economic, social, political, technical and educational; affect the way health services are delivered and health care teams are formed. Furthermore, different resources like human resources, finance and technical support available to different health care organisations and systems also vary.

Health care organisations including hospitals are established to meet a particular objective in society for service users, and they are supposed to achieve desired goals within the national, social and organisational context. Health care is a multifaceted activity which requires health care professionals to work together for service users in a collaborative way to deliver desired outcomes. Hospitals are a part of the health care delivery system and are complex organisations humming with activities of heterogeneous groups of people such as doctors, nurses, paramedical and administrative staff, all working with a common goal of providing medical care to the patients (Kaini, 2005). Understanding the wider picture of Nepal and its major health indicators are necessary in order to further explore the health care delivery system in Nepal. Therefore, this chapter

begins with a brief country profile of Nepal. Health care delivery systems and different types of hospitals are described in detail in the second part of this chapter. The third section in this chapter is about three health care professionals - medical, nursing and allied health professionals and their regulatory bodies. Finally, characteristics of three hospitals where the research was conducted and the research participants or teams of health care professionals are described at the end of this chapter.

5.2 Nepal Country Profile

Nepal is a small landlocked and developing country situated in South East Asia between India in the East, South and West and China in the North. It has a total land area of 147,181 square kilometres. The population of Nepal is 26.49 million (CBS, 2011). Nepal is a secular and federal country. It is divided into three ecological regions – mountain, hill and plains (*terai)* and five development regions, 14 zones and 75 districts for administrative purposes. Each district is divided into small areas called the Municipalities and Village Development Committees (VDCs). The VDCs are rural areas and Municipalities are urban areas of the country.

According to the Central Bureau of Statistics (2011), there are 125 diverse ethnic groups in Nepal, each with its own distinct language and culture. There are 123 languages spoken as mother tongues as reported in the National Census 2011 (CBS, 2011). Nepali is the official language of Nepal written in *Devanagari* script and it is used and understood by most of the population in the country.

Gross per capita income was US$540 in 2011 (World Bank, 2012). According to the Nepal Living Standard Survey 2011, around 25 percent of the population lives below the poverty line (CBS, 2011a). The major occupation is agriculture in the country with 76 percent of households involved in agricultural activities and remittances is the second

foremost sources of income as 56 percent of households receive some types of remittance (CBS, 2011). The following table gives some statistics of Nepal.

Table 2: Basic Statistics of Nepal

Border	North: Tibet, Autonomous Region of China South, East and West: India
Area	147,181 Sq. km (Roughly a brick shaped)
Area Regions (Ecological)	The Mountain (35%), The Hills (42%) and The Terai (Plains) (23%) (all running east to west)
Population*	26,494,504 (2011)
Population Growth Rate*	1.35% per annum
Mean Family Size*	4.88
Religion*	Hindu: 81.3%, Buddhist: 9.0%, Islam: 4.4%, Christianity:1.4%, Others: 3.9%
Capital City	Kathmandu
Administrative Division	Developmental region: 5, Zone: 14, District: 75, Municipality: 58 and Village Development Committee: 3,913
Transportation Roads**	Road Total: 23,454 km (Black-topped: 9917 km, Gravelled: 5715 km, Earthen: 7822 km)

GDP per Capita*	US$735 (2011/12 estimated)
Exchange Rate	US$ 1 = NRs 102.31 (15/9/2013)
Literacy Rate*	65.9% (Males: 75.1%, Females: 57.4%)
No. of Schools*	Total: 34,361 (Primary: 33,881; Lower Secondary: 13,791; Secondary: 7,936, Higher Secondary: 3,382)
No. of Universities	11
Crude Birth Rate*	24.3 per 1000 population
Crude Death Rate*	8.3 (in 2006) per 1000 population
Maternal Mortality Rate^	229 deaths per 100,000 births
Life Expectancy at Birth*	Male: 63.6 years; Female: 64.5 years (2006)
Infant Mortality Rate***	46 per 1000 live births
Total Fertility Rate (Per woman)*	2.6 births per woman

Sources: *CBS (2011), ** Department of Road (2012), ***MOHP (2011), Nepal Demographic and Health Survey; ^ MOHP (2012a).

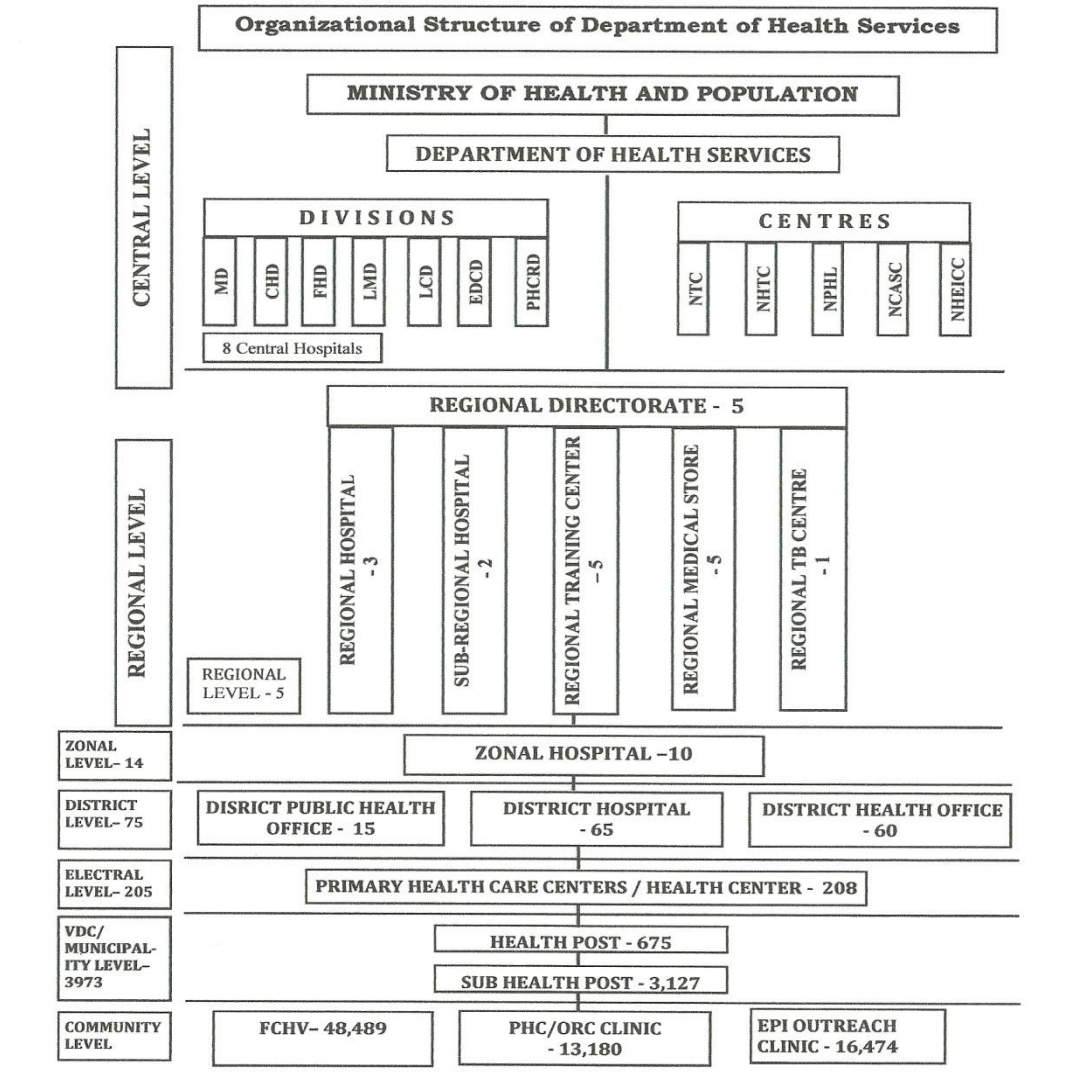
5.3 Health Care System and Hospitals in Nepal

The current health services or facilities and structures under the Ministry of Health and Population (MOHP), Nepal Government are shown in Figure 3. There is a multi-tier health delivery system based on the different levels of care - tertiary, secondary and primary care. The principle of health services delivery is that the Central and Regional Hospitals offer the tertiary level of care, whereas the Zonal and District Hospitals provide

the secondary level of health care services in Nepal. Health services are centrally financed in Nepal with differing degrees of local autonomy and the control of service delivery rests largely in the hands of the relevant professions.

At the bottom tier of the primary health care level, there are Health Posts (HP) and Sub Health Posts (SHP) at the Municipalities and Village Development Committees (VDC) to provide curative and preventative services through static and mobile centres. Primary Health Care Centres (PHC-C) or Health Centres (HC) are established at the Electoral Constituency level. There are hospitals with in-bedded units and certain diagnostic facilities at the District level. District Health Offices (DHOs) manage all these facilities upto the district level. Above this structure, there are Zonal Hospitals at the zonal level and regional and sub-regional hospitals at the regional level to provide specialist health services. Furthermore, there are central hospitals mainly in the capital city Kathmandu to provide tertiary and specialist care for certain specialities such as Mental Health, Heart, Children, Maternity etc. According to the MOHP (2012a), there are 4,393 health care facilities including 105 hospitals (Central, Regional, Zonal and District hospitals) under the MOHP. There are 6944 hospital beds available under the MOHP and a total of 25,376 personnel work in various health care facilities and offices under the Ministry of Health and Population (MOHP, 2012a). The delivery of the public sector health service is managed through various institutions as described above and through various outreach clinics and services at the community.

Figure 3: Health Care Delivery in Nepal by the Ministry of Health and Population



According to the MoHP (2011a), the expenditure for the health sector has increased in relation to total government expenditure from 4.5 percent in 2004/05 to 6.1 percent in 2009/10 (MoHP, 2011a). The Government of Nepal introduced the Free Heath Care programme in 2007. All health services, up to primary health care centre (PHCC) level and 35 different types of medicines are free for everybody. The Government of Nepal also offers free services, provided by district hospitals to six target groups (poor, ultra

poor, female community health volunteers, senior citizens above 60 years old, helpless and disabled). Despite increased spending for the health sector from the government and free health care schemes, private sector spending on health remains high (Stoermer et al, 2012). According to the National Health Accounts estimate (2008/09), private households in Nepal bear 55 percent of the expenditure on health in the form of out of pocket payments (MoHP 2012b).

Apart from government health care facilities as mentioned above, a number of private hospitals, nursing homes, medical colleges are also established in Nepal. A hospital is an independent legal entity and the legal basis of the hospital establishes the institution and determines the type and nature of the hospital (Kaini, 2005a). There are mainly three different types of legal status of hospitals in Nepal – public, private and non-governmental organisation (NGOs) or voluntary organisation run hospitals. Public hospitals are those hospitals, which are directly under government control and are public funded hospitals as described above.

The second category of hospitals is those hospitals established and run by the NGOs in Nepal. The NGOs are not-for-profit and voluntary organisations and they can establish and run hospitals as a part of social service to the community. They are registered with the District Administration Office and Social Welfare Council, and licensed by the Ministry of Health and Population (MOHP) to run hospitals. NGOs are one of the most important partners of public sector health services in rural areas and are recognised as indispensable allies in the delivery of primary care, not only because they supplement government resources but also because there is much to be learnt from their experiences, expertise and innovative ventures (Paudel, 2009).

The third type of hospital and health care institution is private hospitals established and managed by the private companies with the intention of the delivering health care and

returning a profit. The private hospitals are registered with the Company Registrar's Office under the Company Act and are licensed by the MOHP. Private hospitals and health care institutions are run by individuals or by commercial companies. Individuals who run private health care organisations on a full time or part time basis are mostly health care professionals. It is common practice in the urban areas in Nepal that many public sector health care employees set up their own private clinic or work in other private clinics as part time employees alongside their regular job in the public sector hospitals. Not only the rich, but the poor also prefer private health care, which suggests private health care facilities play a complementary role in providing health services to the people (MoPH, 2010a).

The private pharmacy stores also act as a clinic and dispense medicines including controlled drugs and antibiotics. The private commercial organisations are usually named 'Nursing Homes' in Nepal, which is similar to the hospital in terms of provision of health services and facilities. Due to the government's policy to involve private health care organisations in Nepal, there is an increasing trend to establish private nursing homes in the urban areas in Nepal. There are 301 private hospitals in Nepal (CBS, 2014) and most of the private hospitals provide secondary care and are established at the zonal and regional headquarters, and very few are established in the district headquarters. It shows that secondary or tertiary health care services are mainly focused in major cities and towns in Nepal. Many Nepalese people still believe in herbal medicines and have faith in traditional healers to cure their illnesses and quite a few still visit *Ayurvedic* and *Homeopathic* practitioners. Apart from these facilities, there are thousands of private clinics and laboratories who provide access to various forms of medicines (Paudel, 2009).

According to Rai et al (2001), due to shortage of resources, poverty, urbanisation and rapid population growth; Nepalese hospitals are *'not sufficient to combat health problems*

in Nepal' (p.2). The National Planning Commission in its interim plan (2007 - 2010) highlights various problems and challenges in the delivery of health care services in Nepal such as the lack of skilled human resources and problems in their mobilisation to health centres; weak supervision; lack of physical infrastructure and inadequate repair and maintenance of physical infrastructure; and inadequate supply of equipment and drugs (National Planning Commission, 2007).

In this context, a multi-sector approach in the delivery of health care was adopted by the Government of Nepal. The health service has gone through a massive restructure and change since the restoration of democracy in Nepal in 1991 (Rai et al, 2001). One of the objectives of *The Tenth Plan* (2002 - 2007) in Nepal was to establish public-private-Non Governmental Organisations partnerships in the delivery of health services, and improving the quality of health care through total quality management of human, financial and physical resources (National Planning Commission, 2003).

The number and types of health care professionals involved in delivering health care to service users and to the entire population has been growing due to increased complexities in this field (Hawley, 2007). The health service in Nepal is the biggest employer group of public services and it has more than 50 careers, most of which are qualified, registered or regulated professionals (MOHP, 2012). With such a diversity of professions, it is obvious that co-ordinated patient care requires communication, interaction and joint decision making between health care professionals (Reel and Hutchings, 2007). Callaghan (2006) states that the demands of a forever changing health care environment requires medical, nursing and allied health care professionals to seek new ways of delivering advances in health care that will be of ultimate benefit to the patient. Central to the success of interprofessional care is to engage in collaborative practice by ways of nurturing interprofessional working (Reeves et al, 2010).

5.4 Health Care Professionals and Their Education System in Nepal

The health care team is composed of a number of professionals of different backgrounds, education, training, experience and theoretical viewpoints. They differ not only in the resources they bring to the team, but also in role expectations, status, and the extent of their legal responsibility for the service users (Duncanis and Golin, 1979). Among the professions often represented on the team are medicine, nursing and allied health professionals. Duncanis and Golin further describe each health care team as a unique blend of professional and personal characteristics of its members, its effectiveness determined largely by the dynamics of that configuration.

Professional bodies such as Nepal Medical Council (NMC), Nepal Nursing Council (NNC), Nepal Health Professionals Council (NHPC) play an important role in shaping interprofessional working and in helping their members with their interprofessional working. These three professional bodies should work together to create a collaborative and safe working environment for service users and their members. They have also developed professional values and norms to underpin collaborative working in consultation with their members, service users and many other organisations across the board.

Health care professionals are divided into three professional groups in this study – medical professionals, nursing professionals and allied health professionals. The following sections give a brief overview of these three professional groups and their education system in Nepal.

Medical Professionals in Nepal: Medical professionals undergo extensive training and education to be qualified as a medical doctor in Nepal. Candidates should have at least intermediate level (equivalent to 'A- level' in the United Kingdom) or 10+2 level higher

secondary education in science (including biology and chemistry) with competitive scores to be eligible for applying for the MBBS courses. The 4 ½ year MBBS courses in Nepal are accredited and regulated by the Nepal Medical Council and the Ministry of Education, Government of Nepal. The course consists of basic medical sciences in the first two years and $2^{1/2}$ years of clinical subjects. After passing the final MBBS examination, all students are required to undergo one year of compulsory rotary internship in a hospital or in a health care facility, according to the rules and regulations of medical universities and the Nepal Medical Council. There are 20 medical colleges and universities offering MBBS courses in Nepal. Then, medical students specialise in their fields of interest at the post-graduate levels.

The medical professionals in Nepal are regulated by the Nepal Medical Council (NMC). According to the NMC (2012), its main purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The law gives the NMC the following four main functions*:*

- To determine the qualification of doctors and to provide registration certification by taking licensing examinations for new doctors.
- To give recognition to medical institutions for providing formal studies in medical science and training.
- To formulate policies related to curriculum, admission, term and examination systems of the teaching institute of medical education and to make recommendations for cancellation of registration and approved by renewing and evaluating such system/procedure.
- To formulate necessary policies and to make Codes of Conduct to run doctors profession smoothly.

(NMC, 2012)

The NMC primarily exists for medical professionals and they work on behalf of their members rather than focusing on the users of the professional services. Hammick et al (2009) describe that professional bodies have a role in creating interprofessional practitioners and they need to be interprofessional, learning and working from and with each other.

The General Medical Council (GMC) in the UK published guidance '*Management of Health care: The Role of Doctors'* (GMC, 1999) and observed that 'health care is increasingly provided by interprofessional care teams' and acknowledged that such collaboration brings benefits to patient care and to health care professionals. However, they warned that if interaction and communication is poor, between the team members and health care professionals, problems can arise. An approach to avoid this was recommended in the guidance, which stated that interprofessional care teams should be clear about their objectives in order to facilitate collaboration and communication and to improve the quality of the teamwork (GMC, 1999). The GMC '*Guidance on continuing professional development*' (GMC 2004) also makes it clear that a doctor is expected, amongst other things, to 'explore the benefits of learning across professional disciplines and boundaries'. There was no such literature found in the Nepal Medical Council's code of conduct and guidance that describes interprofessional working, team collaboration or collaborative practices in Nepal

Good Medical Practice (GMC, 2006) in the UK describes the nature of good doctors. It says good doctors are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity. In summary, essential elements of good doctors include professional competence, good relationships with all stakeholders including colleagues

and compliance of professional and ethical obligations. Doctors are accountable for providing medical care within the team and for her or his own professional conduct. In this context, doctors need to ensure that all team members understand their personal and collective responsibility for safety of the patient.

Nursing Professionals in Nepal: The registered nurses in Nepal usually undergo a 3-years course run by universities or the Council for Technical Education and Vocational Training (CTEVT) to be qualified as a registered nurse. The eligibility criteria for them to get enrolled for the 3-years nursing course is to have a minimum of School Leaving Certificate (SLC) (a national board exam after passing the 10th grade, which is equivalent to the GCSE in the United Kingdom). Various technical colleges and institutions run Auxiliary Nursing and Midwifery (ANM) courses with a duration of 15-months plus 3-months of on-the job-training for the SLC pass trainees and 2-years plus 5-months on-the job-training for the tenth grade pass trainees. The registered nurses can go for further education which is usually Bachelor of Nursing (BN) course after two-years of clinical practice. Registered nurses can enrol in the 3 broad categories of nursing specialities - adult nursing, mental health nursing and child nursing at post graduate level of education. Few medical colleges also run Bachelor of Science (BSc) in Nursing courses for those who have only passed intermediate level or 10+2 level of the higher secondary education in the basic sciences.

The Nepal Nursing Council (NNC) is the nursing and midwifery regulator in Nepal. According to the NNC, the following are the objectives of its existence:

- To formulate policy required to operate the nursing profession smoothly
- To provide recognition to a teaching institution

- To evaluate and review the curriculum, terms and conditions of admission, examination system and other necessary terms and conditions and infrastructure of a teaching institution
- To determine the qualifications of the nursing professionals and to issue certification to the qualified nursing professional after registering his /her name in the registration book
- To determine the work limit of nursing professionals
- To formulate professional codes of conduct of the nursing professionals and to take action against those nursing professionals who violate such codes of conduct.

(NNC, 2012)

The Royal College of Nursing (RCN, 2012) has defined the nursing profession as 'the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death'. Adult nursing, children's nursing, and mental health nursing are the three main categories of nursing disciplines. Based on the roles, the nursing teams work in collaboration with various professional groups such as therapists, dietician, pharmacists, doctors etc. Individual registered nurses work in various specialities and settings using different skill sets. However, their goal is common, to take care of the nursing needs of patients as described above. Sullivan (1998) states that nurses play an important role in the delivery of health care and improving quality of care.

The Nursing and Midwifery Council in the UK develops standards of proficiency for all nursing and midwifery professionals they represent. The phrase 'collaborative working' is used frequently in this set of standards. The Nursing and Midwifery Council (2012)

spells out their view on this: ‘it includes working with others working in health and social care; those working in social security, benefits, education, housing and the environment; those working in advice, guidance and counselling services; employers and employees in a range of different sectors; voluntary agencies; community networks and legal and judicial agencies’. One of the nursing standards is that every nurse can ‘demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team’ with another being that the nurse can ‘work in a team with other nurses, and with medical and paramedical staff and social workers related to the care of the particular type of patient with whom they are likely to come into contact when registered at this level of the nurses’ part of the register’. One of the main principles for the standards of proficiency relates to the management of care one aspect of which ‘involves the capacity to work effectively within the nursing and wider multidisciplinary team, to accept leadership roles within such teams, and to demonstrate overall competence in care and case management’. In common with nurses, midwives are also expected not only to ‘work collaboratively with other practitioners and agencies’ but also to ‘demonstrate effective working across professional boundaries and develop professional networks’ (Nursing and Midwifery Council, 2012). There was no literature found in the Nepal Nursing Council’s code of conduct or standard of practices that is related to collaborative practices or interprofessional working in health care.

Allied Health Professionals in Nepal: There are various entry routes to various levels and categories of allied health professionals in Nepal. Many courses such as Health Assistant (HA), Community Medical Assistant (CMA), Dental Hygienist, Laboratory Technicians, Radiography Technician, Pharmacy Assistant etc. are run by the CTEVT and by other technical schools and colleges under the accreditation of the CTEVT. Trainees are required to pass the School Leaving Certificates level exams to be eligible

for the courses with a duration of 15 months plus 3 months of on-the job-training. Trainees for the 2-years plus 5-months on-the job-training should pass the tenth grade to be eligible for the courses. Medical colleges and universities also run 3-years undergraduate courses on laboratory, radiography, general medicines and pharmacy for those who pass the intermediate level or 10+2 higher secondary level in basic sciences. Allied health professionals who pass their exams from the accredited bodies, councils, universities and colleges are eligible to register under the Nepal Health Professional Council (NHPC). The NHPC was established in 1997 and regulates the following allied health care professionals in Nepal:

> *arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers.*
>
> (NHPC, 2012)

The term 'allied health professionals' mentioned in this research represents the professionals stated above. The aim of this council is to register all health professionals other than medical doctors and nurses according to their qualification; and bring them into a legal system so as to make their services effective and timely, and in a scientific manner.

The NHPC's main purpose is to safeguard the health and well being of persons using or needing the services of registrants. Its role is to formulate registration standards, approve and run education and training activities, maintain a register of allied health care professionals who successfully complete such programmes and take action if standards are not met. It has the statutory power to make recommendations to the Ministry of

Health and Population on the regulation of new groups. One of the standards set by the NHPC relates to curriculum standards wherein it states that where there is interprofessional learning, the profession specific skills and knowledge of each professional group must be adequately addressed.

The NHPC (2012) has highlighted the following expectations of health care professionals on 'generic standards of proficiency'. Some of the standards refer to professional autonomy, responsibility and accountability; and the others focus on professional relationships, teamwork and communication: According to the generic standards of proficiency, registrants should:

- Know the professional and personal scope of their practice and be able to make referrals.
- Be able to work, where appropriate, in partnership with other professionals, support staff, patients, clients and users, and where their relatives and carers understand the need to build and sustain professional relationships as both an independent practitioner and, collaboratively as a member of a team, understand the need to engage patients, clients, users and carers in planning and evaluating care.
- Be able to contribute effectively to work undertaken as part of a multi – disciplinary team
- Be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, users, their relatives and carers
- Understand the need for effective communication throughout the care of the patient, client or user'

(NHPC, 2012)

To practise ethically and to keep their standards up-to-date, health care professionals follow professional codes of standards and conduct, published guidelines and protocols, ethical values and social norms. Furthermore, the terms of reference of job contract defines roles, responsibilities, accountabilities, authorities, hierarchies and expectations of the roles (Colyer, 2012, p.187).

The following table shows the number of registered health care professionals under different professional councils in Nepal.

Table 3: Number of Health Care Professionals in Nepal

Categories of Professions	Headcount (Number)	Percentage
Doctors (including 11359 medical doctors and 1222 dental doctors)*	12,581	12%
Qualified nurses**	19,098	19%
ANM**	19,222	19%
Foreign Nurses**	739	1%
Qualified allied health professionals (scientific, therapeutic & technical staff)***	50,404	49%
Total	102,044	100%

*Number obtained from NMC on 30 January 2013 under Freedom of Information (FOI) request.

**Number obtained from NNC as of 15 October 2012 (Source: http://www.nnc.org.np) (renewed status up to 15 Oct 2012, Nurses – 5777 and ANM 2304, total 8081)

***Number obtained from NHPC on 11 Dec 2012 under FOI request.

5.5 Interprofessional Working in Nepalese Health Care Context

The health policy agenda in Nepal for the last few decades has been dominated by the ideas of improving access and delivery of primary health care for a section of marginalised and underprivileged population (Kaini, 2013). One of the main objectives of the National Health Policy 1991 is to extend the primary health care system to the rural population so that they benefit from modern medical facilities and trained health care providers (Ministry of Health, 1991). Reducing infant, child and maternal mortality; improving access of health services and decreasing disparities in health status have been the priorities of the national health strategies and policies in Nepal. The Second Long Term Health Plan (1997 – 2017) was formulated to improve the health status of the entire population with a major focus on accessibility and equitability of the health services to those groups; such as the children, the poor, the underprivileged and the marginalised population; whose health needs are not often met (Ministry of Health, 1997).

Secondary or tertiary health services in Nepal are mainly established in major towns or cities and are provided by public and private sectors. At secondary or tertiary care level, improving health services, developing health infrastructure and strengthening the capacities of clinical staff have never been the priority of health polices or strategies in Nepal (Regmi et al, 2004); this is mainly due to the limited capacity or resources and huge disparities of health services in the remote and urban areas (MOHP, 2012).

Never has the collaborative practice resultant from teamwork been more needed than in these recent years for the health care service sectors in developing countries (Yang and Yu, 2006). I have spent about fourteen years in Nepal and almost ten years in the United Kingdom in the health and hospital management sectors and have long been aware of the importance of teamwork with regards to effective delivery of health care and team performance. Interprofessional collaborative teamwork in health care practice is

becoming the main feature to meet service users' needs (Beattie et al, 1996) and to deliver desired health outcomes.

Hospitals play a vital role providing services to the sick. A hospital is an open system, which interacts with its environment. The various professions and their interaction for patient and service users in the hospital influences the overall health and social wellbeing of a patient and community (Reeves et al, 2009). Hospitals consume a huge chunk of public expenditure allocated to health care (Kaini, 2005b). If various health care professionals do not interact well, the resources will not be used efficiently and effectively and patients will not get optimal desired outcomes (Hall, 2005). In other words, interprofessional working between health care professionals in hospitals affects patient care. According to Bates (2005), the complex nature of collaborative working has important implications for the delivery of health and social services, and is carried out by an enormous range of providers, often to the most vulnerable and marginalised groups in society.

The workload in hospitals in developing countries has increased over recent years (Gidman et al, 2007, p.290). Low-income countries are struggling under a large burden of communicable diseases, while also confronting increases in the prevalence of non-communicable diseases and injuries, a trend that will likely continue for some time (Lopez et al, 2006). The availability of resources to meet these numerous health needs is limited (Mathers et al, 2006). Workload in Nepalese hospitals has increased due to an increase in population, and increased awareness on health and well being (MOHP, 2012). Thus improved co-ordination is vital within various departments in hospitals to cope with increasing demands. The increase of interaction and input has intensely altered the way of management of health care in hospitals. Due to this, various staff members at hospitals,

like doctors, nurses and allied health professionals now have an enhanced influence on one another (Malone et al, 2007).

Good health care does not just happen. It is a result of a combination of informed people and institutions, functioning together with a common purpose. Governments in developing countries have different priorities. Due to a lack of resources, they mainly focus on the delivery of primary health and community care. Community health centres and public health institutions are the only hope for underprivileged people in Nepal. The secondary care is provided jointly by the government and the private sector. Developing countries account for 84 percent of global population, 90 percent of the global disease burden, and 20 percent of global GDP, but only 12 percent of global health spending (Mathers et al, 2006).

Inter-agency partnership working is one of the key themes of the Nepal government's health care policy (MoHP, 2009). However, in the Nepalese health care context it is difficult to find a government policy document or guidance from professional bodies that mention interprofessional working as a key theme for the delivery of health care. During my research in Nepal in 2013, I visited many libraries (including Central Library, Library of Institute of Medicines, Ministry of Health, and Nepal Health Research Council) and various health care organisations to find out if there is any literature available on interprofessional working in hospitals and health care institutions in Nepal. I did not find any evidence and literature to show that research on interprofessional care, teamwork and interprofessional team collaborative practices had been carried out in Nepal in the past.

The burden on the health and social care system is growing each year (Lopez et al, 2006). According to Naicker et al (2009), health care institutions are facing challenges to offer efficient and effective services while at the same time working with limited resources. To tackle this issue, improved and new approaches of care systems are required to meet the

growing pressure. An interprofessional team based collaborative approach to health care would be an enabler for improving patient care and meeting the new challenges that the system is facing (Hammick et al, 2009). This holistic interprofessional care system offers quality and comprehensive health service to health service users by different health care professionals in a systematic way (CIHC, 2009). Duncanis and Golin (1979) suggest that the similarities, differences and the area of overlap among the health care professionals provide a source of potential conflict and misunderstanding which can have considerable impact on team functioning.

In developing countries, health care professionals play a vital role in improving access and quality health care for the population and provide essential health and social services that promote health, prevent diseases and deliver health care services to individuals, families and communities based on the primary health care approach (WHO, 2012). The WHO (2006) emphasises a worldwide shortage of almost 4.3 million doctors, midwives, nurses and support workers and most of the shortages are observed in developing countries. According to Reeves et al (2010), an appropriate system for enhancing and optimising the capability and joint working between health care professionals is essential to achieving the health service for all in developing countries.

From the review of literature and a wide variety of articles and publications, it is noted that no policies, guidance and strategies have been developed and no directives given for interprofessional working in health and social services in Nepal. Tope and Thomas (2007) emphasise that the creation of a favourable environment for interprofessional working and an interprofessional workforce are critical for the health and social care of future generations. They further argue that health service users' voices were being heard and what they wanted and needed was some 'joined up thinking' between health care professionals and all those involved in their care. The need for collaboration between

health care professionals and organisations and the promotion of partnerships across interfaces of primary care in the community, secondary care in specialised institutions, health authorities and social services is important for an excellent outcome (Casto and Julia, 1994). It is also important for a seamless service across organisational boundaries (Keleher, 1998).

5.6 Introduction of Participating Hospitals

This study was carried out in the following three hospitals in Kathmandu, the capital city of Nepal. One hospital from each sector - public, voluntary/not-for-profit and private was selected as described in the earlier Chapter 4 Research Methodology.

Shahid Gangalal National Heart Centre (SGNHC): The SGNHC was established in 1995 in Kathmandu by the Government of Nepal as a national referral and tertiary centre for heart diseases in Nepal. It is a fully fledged national cardiac hospital and it provides specialist and tertiary care in the field of cardiology and cardiac surgery including all kinds of open and closed heart surgeries, intensive care units, cardiac care units, inpatient units, interventional cardiology (angiogram, angiography, catheterisations, angioplasty, stent replacement, electrophysiology studies and pacemaker implantations), invasive and non-invasive cardiology. According to the SGNHC (2013), it has a total workforce of 269 staff including 67 medical, 107 nursing, 41 allied health professionals and 54 administrative staff.

Tilganga Institute of Ophthalmology (TIO): The TIO was opened in 1994 in Kathmandu. It is a non-profit, community based non-governmental or voluntary organisation. It aims to provide state of the art eye care services and act as a role model for treatment, research and training on all aspects of eye care in Nepal. Currently it provides all types of services including outpatient, inpatient, diagnostic, operating

facilities in community, primary, secondary and tertiary eye care in Nepal. According to the hospital sources, it employs 316 staff (22 medical, 64 nursing, 54 allied health professionals and 176 other staffs).

Medicare National Hospital and Research Centre Limited (MNH): The MNH was established with a 30 inpatient unit in 1997 in Kathmandu. It is a private general hospital owned by medical doctors and business entrepreneurs. It provides secondary and tertiary care in cardiology and cardiovascular surgery, general medicine, neurology, orthopaedic, urology, ear, nose and throat (ENT), oncology, nephrology, paediatric, psychiatry, ophthalmology, general surgery, dermatology, gastroenterology, physiotherapy, inpatient, intensive and cardiac units, family health, diagnostic and maternity services to private patients. According to the MNH (2013), there are 302 staff working in the hospital including 81 medical doctors (including part time, session basis and full time doctors), 80 nursing staff, 41 allied health professionals and 19 administrative staff.

5.7 Summary

This chapter describes the role of public, private and voluntary or not-for-profit sectors in the delivery of health services in Nepal. Health services in Nepal are financed and delivered by the Government of Nepal at primary, community, secondary and tertiary levels. The private hospitals and nursing homes are established in the big cities and urban areas and can be seen as major players for the delivery of health services. Similarly, voluntary sectors also offer different services in different parts of the country and mostly offer community based services. The main focus of the health delivery system in Nepal is to improve health care access to the marginalised population, specially those living in the rural area; and to strengthen resources for the delivery of primary and secondary health services across the country.

The health education system in Nepal for nursing, medical and allied health professionals is similar to many other developed countries. There is a major focus on university academic programmes for the undergraduate and postgraduate qualifications and vocational training and education for producing junior level health care professionals. All three health care professionals – nursing, medical and allied health professionals are regulated by their respective professional councils. The professional councils also set professional codes of conduct and good principles of practice in Nepal.

Inter-agency collaboration in health care is one of the priorities set by the Government of Nepal in its policy document. However, there are no other policy documents at local, regional and national levels found to support and encourage interprofessional working between health care professionals. Even though there is much research carried out and literature published in the developed health economies in the field of interprofessional working, there is no literature published in developing countries and Nepalese context in this field. Therefore, this study aims to fill in the gaps by examining how health care professionals in Nepalese hospitals collaborate and by assessing their perceptions of interprofessional working. This study also aims to recommend various ways to improve interprofessional working practices in Nepal.

Chapter 6: Perceptions and Understanding of Interprofessional Working among Health Care Professionals in Nepal

6.1 Introduction

The previous Chapter describes the research methodology and the analytical framework to analyse the data generated from the interviews. The data in this section is gathered from interviews from three groups of health care professionals – nursing, medical and allied health professionals in the three hospitals under study. Moreover, hospital strategies, policies, protocols and documents related to interprofessional and team working were analysed. The data analysis was carried out through a careful and thorough examination of interview narratives and review of documents. This chapter looks at categories and themes arising from the data from the semi structured interviews with the three groups of health care professionals.

The chapter starts with the characteristics of participants, in order to find demographics of participants including the type of hospital they belong to, the department they work for, their professional group, educational background and gender. Then, it follows with the presentation of various themes and sub themes. This chapter is divided into various sections based on the major themes and categories derived from the analysis of interview data. The core categories are divided into sub-categories in a few cases and further linked with other categories as required. In each section, interview data is presented by professions and hospitals. There are comparisons between different professionals and different types of hospitals where the data allows it.

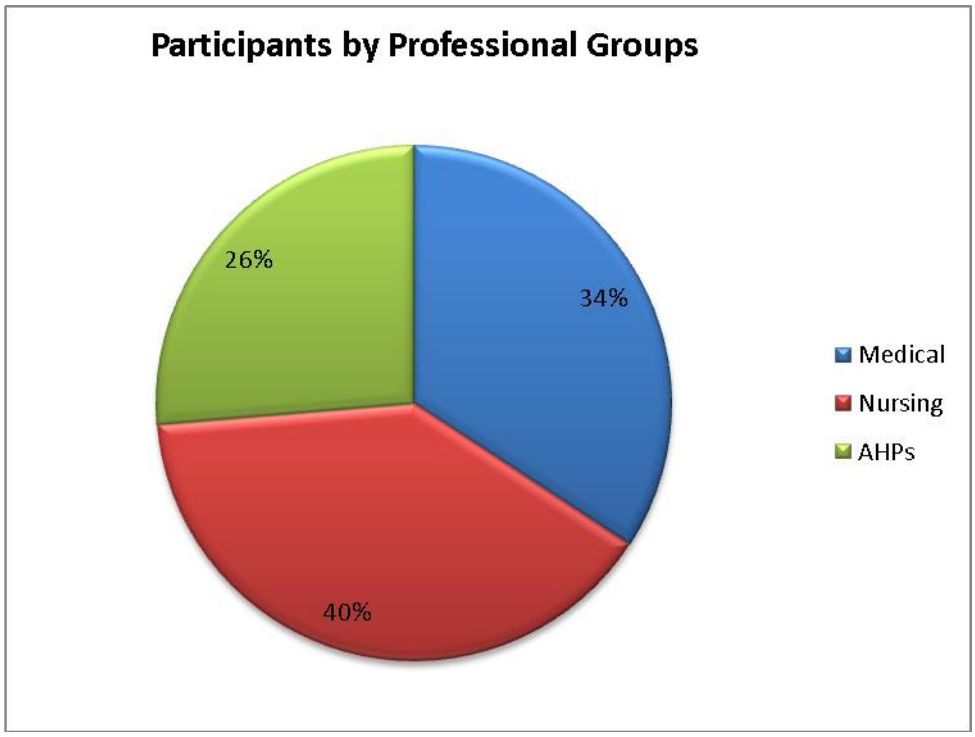
6.2 Characteristics of the Participants

The participants in this research are registered health care professionals working in the three hospitals and they are categorised in three groups – nursing, medical and allied

health professionals. Demographics of participants including the type of hospital they belong to, department/specialty they work for, current job title, professional group of participants were asked at the beginning of the interview. This section was included to discuss characteristics of the research participants and to categorise the participants into different groups according to their professional attachments and hospital types. All questions in the first part of the interview schedule were close questions with options, except current job title and department. All participants completed all sections of the first part of the interview schedule without any hesitation at the beginning of the interview. The main purpose of including this section in the interview schedule is to make comparisons of participants' experiences, perceptions and understanding between different health care professionals and hospitals. This also helps to examine correlations between interprofessional working practices and participants' background.

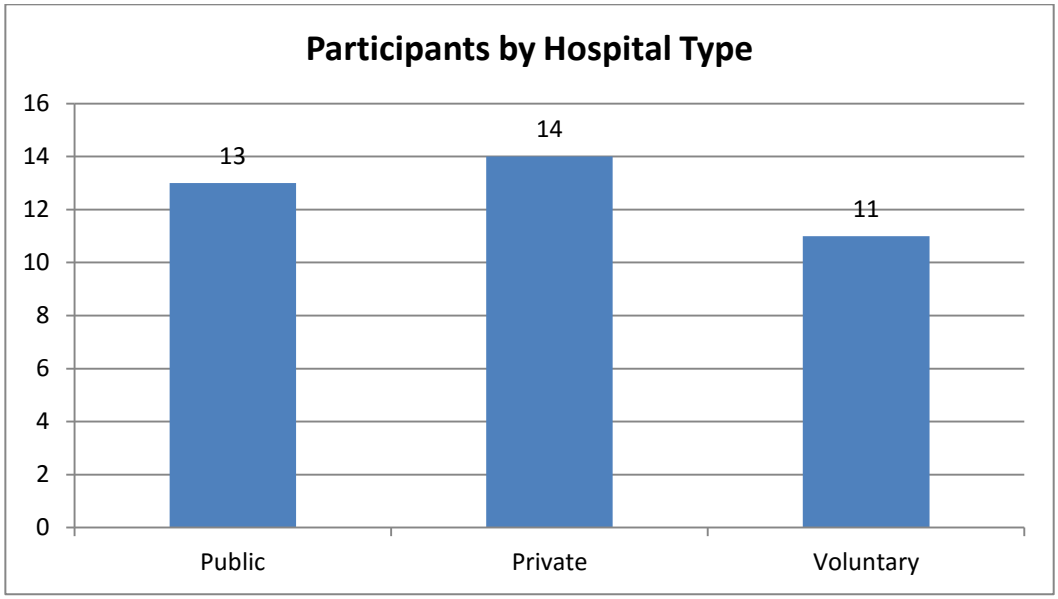
A total of 38 health care professionals participated in this research from three different hospitals. Of the total participants, 40% (n=15) were nurses, 34% (n=13) were medical professionals and 26% (n=10) were allied health professionals. The study population was representative from each professional group as nursing is always the largest professional group in hospitals followed by medical and allied health professionals. The detailed breakdown of the participants of health care professionals is shown in Figure 4.

Figure 4: Participants by Professional Groups



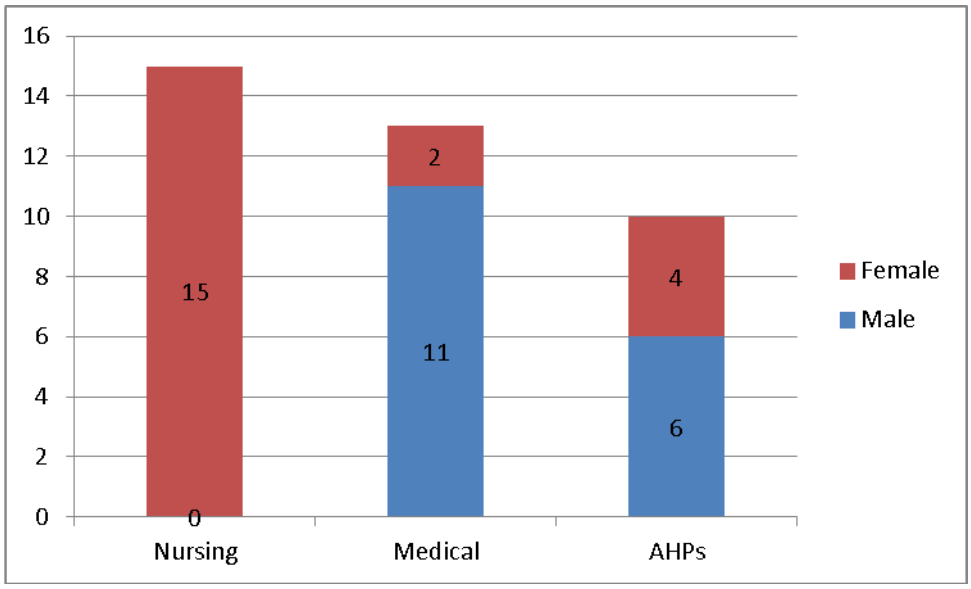
As shown in figure 5, there were 13 health care professionals from the public hospital, 14 health care professionals from the private hospital; and 11 health care professionals from the not-for-profit or voluntary hospital.

Figure 5: Participants by Types of Hospitals



As can be seen in Figure 6, all nurses are female due to a provision whereby only females are eligible for nursing courses in Nepal. The medical profession is predominantly a male's profession in Nepal. The figure below shows that 85% (n=11) medical professionals who participated in the research are males and the rest are female doctors. The proportion of male to female participants in the allied health professionals is 6 to 4 as shown in Figure 6.

Figure 6: Participants by Gender



The participants were asked to state their academic or vocational qualification. Figure 7 below shows the breakdown of qualification of the research participants. None of the participants have a vocational qualification. All participants are qualified and registered with their respective professional councils to practice legally in Nepal. A total of 47% (n=18) have undergraduate qualifications and 53% (n=20) have postgraduate degrees. Most of the medical professionals (85%, n=11) have passed postgraduate degrees and only 15% (n=2) doctors are undergraduates. Amongst the nurses, the proportion of under graduate and postgraduate nurses is almost equal (47% under graduate and 53% post graduate). Of the total allied health professionals, 80% (n=8) have undergraduate degrees

and only 20% (n=2) have postgraduate qualifications. This data shows the participants' capability and knowledge to provide reliable and valid accounts based on their knowledge, experience and skills.

Figure 7: Health Care Professionals by Qualification

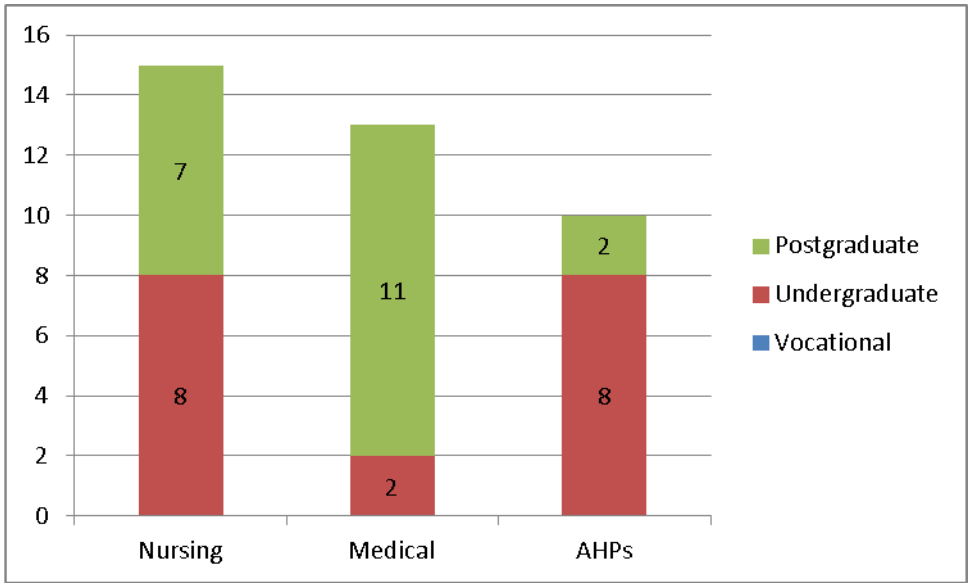
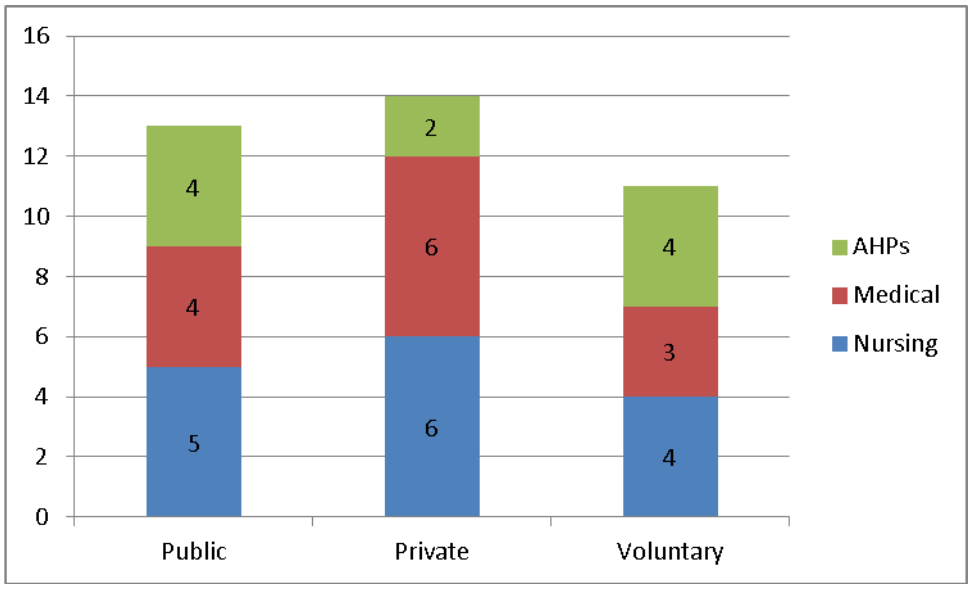


Figure 8 below shows the breakdown of participants or health care professionals by different hospitals. In the public hospital 5 nurses, 4 medical professionals and 4 allied health professionals were interviewed whereas in the private hospital 2 allied health professionals, 6 nurses and 6 medical professionals participated in the research. A total of 11 participants were interviewed in the voluntary hospital, of which 3 medical professionals, 4 medical and 4 allied health professionals took part in the research.

Figure 8: Health Care Professionals by Type of Hospitals



6.3 Medical Dominance and Interprofessional Relationships

One of the themes identified from the interviews is dominance of medical professionals and its impact on professional relationships between health care professionals. This is one of the important aspects of interprofessional working which is associated with so many other factors such as decision making, professional influence and relationships between health care professionals. Moreover, it has many consequences; and it has an impact on the way health services are delivered; and the way different health care professionals collaborate.

Participants mentioned many reasons why should they were concerned about interprofessional relationships and how it impacts on team performance and delivery of health services. Participants raised various problems of professional encroachment especially from medical professionals, interferences in clinical work from other professionals; lack of equal involvement in decision making; and the way health care teams are managed. Issues related to impact of relationships between health care professionals on service users' health gain or recovery were also raised. Participants

from all hospitals and professional groups shared their experiences of dominance of medical professionals in health care, issues related to impartial involvement of nursing and allied health professionals in decision making and their influence on health care delivery. Therefore, this category is linked closely with medical dominations in health services and its influence on decision making.

Participants (fourteen nursing and 6 allied health professionals; i.e ninety-three percent nursing and sixty percent allied health professionals) from all hospitals (7 from the public hospital, 6 from the private hospital and 7 from the voluntary hospital) perceived that medical professionals dominate overall service delivery aspects in health care and they perceived it as detrimental for interprofessional working relationships. They mentioned various reasons why medical professionals dominate the health care sector. A nurse from the private hospital states:

> *Doctors are seen as the dominant professionals in the hospital. There are many reasons for this; it is mainly because of their education and expertise. (B11-N)*

Most of the participants (13 nursing, 5 allied health professionals and 13 medical professionals from 11 public, 11 private and 9 voluntary hospitals) stated that medical professionals are seen as highly recognised, respected and competent compared to other professionals. They stated that reason for this is due to their education, expertise, high recognition of their professions from the public and other health care professionals, and specialised roles. Few participants (3 nursing and 2 allied health professionals) highlighted that their medical degree and specialised knowledge put them on top of the professional, organisational and team hierarchy in health care organisations and hospitals. A nurse from the public hospital comments how medical professionals feel superior to other professionals:

> *Sometimes when we try suggesting to doctors to carry out something for patient care, they do not easily accept our suggestions and they feel as if we are doubting them or they feel they are superior than us. They might be more educated than us, but we play an equally important role from patient care point of view for improving health of service users. (A10-N)*

One allied health professional from the private hospital highlights the need of equal recognition of all professionals:

> *Even though all professions have to be equally recognised and given equal importance, the doctors completely dominate our profession due to their attitude, social recognition and roles. (B6-A*)

It is positive to note that all participants felt interprofessional working should be sufficiently motivated and recognised amongst health care professionals with adequate appreciation from each other and from all stakeholders. Moreover, few participants (3 nursing, 4 allied health professionals and 2 medical professionals) mentioned that interprofessional working approaches also include, but often go beyond, supporting people in individual or interpersonal situation of need. Interprofessional working in health care is promoted by '*an appreciation of each other's contribution, agreement on the aims and goals in relation to a patient or client and agreed distribution of roles and related tasks*' (Leathard, 2003, p.48). Interprofessional approaches lead to recognition of issues at an early stage for early detection, prevention and intervention. Recognition and authority come together when assigning important roles to health care professionals for successful delivery of interprofessional care. An allied health professional feels sidelined by medical professionals:

We have not been given the authority to produce reports and our signature here is nearly invalid. We (allied health professionals) are seen as helpers by medical professions rather than a secular profession. Therefore, we always feel dominated. If there is such a mentality, we feel it is an encroachment in our authority, which has negative effect to patient care. (C5-A)

The statements above suggest nursing and allied health professionals experienced dominance from medical professions in Nepalese hospitals. Moreover, three medical professionals stated that medial domination exists in Nepalese hospitals. One medical professional agreed that medical professionals get more respect than any other professionals and this may be one of the reasons why they seem more dominant amongst all professions in health care. He states:

I think the respect and recognition to a doctor is more than what is required and that's why doctors feel more proud and empowered than they should be at times. I think people are more esteemed than they should be. So, we are having more respect than we want. People think a doctor is the God which is not correct. (A2-M)

This is the case for medical professionals in private and voluntary hospitals as well. Another medical professional from the voluntary hospital agrees:

Doctors are respected by the society. Other professions in the medical profession also respect the doctors. It might also depend on the attitude of the individuals. But as a whole, we are respected by almost everyone. (C4-M)

One staff nurse mentions why a nurse has to face problems compared to other professionals in relation to the dominance of the medical profession and states the consequences of this:

As a nurse we have to face more problems than any other professionals. It has many causes, because it is a female's profession and doctor dominated profession and it is regarded as an assistant profession, ... we feel dominated by medical doctors. ..... It has many consequences as well, for instance, it may cause delay in patient's care, and personally staff's de-motivation can cause interference in the quality of care. After all it causes problems financially to the organisation and it may affect patient care. (A1-N)

Few nurses (3 nurses; 2 from the public hospital and 1 from the voluntary hospital) felt that dominance of medical professionals creates a boundary between different professions. A nurse from the public hospital states:

Medical domination is one boundary. Lack of involvement in decision making is also the problem. Sometimes other professions keep on overstepping. It affects the service of the patient. It causes declining confidence and also may create anxiety and depression. (A9-N)

A nursing professional from the private hospital expresses concerns that dominance of medical professionals creates division. She puts it:

The medical profession dominates all the other professions in the hospital and it is accepted by other professions. Doctors are seen as God and are highly respected at workplace and in the society because of their status, which creates more problems and division rather than integration between health care professionals. (B3-N)

The hierarchy of health care organisations places medical professionals above allied health professionals and nurses, and medical professionals have thus typically been the decision makers in health care organisations in the traditional context (Hojat et al, 2001).

Therefore, this concept has led to the common practice and concept of nurses and allied health professionals as collaborators and helpers and medical professionals as health care team leaders (Chang et al, 2009 and Larson, 1978). Few nursing professionals expressed that the situation has improved gradually. One nurse from the public hospital comments:

> *Doctors used to dominate us as an auxiliary profession but nowadays it (our profession) is recognised well. (A9-N*)

Due to increased awareness of the roles of health care professionals in health service delivery and the increased number of educational establishments offering education and training to various health care professionals, nursing and allied health professionals felt that the situation is not the same as it used to be. One nurse from the private hospital states:

> *During my earlier years as a nurse, nursing wasn't considered a very highly esteemed profession but the perception has ceased to exist and nurses are respected. That too can be said regarding the other professions. Newly established educational institutions contributed to raise this awareness. (B10-N)*

Another nurse from the voluntary hospital confirms this and states:

> *During the beginning of my practice, nursing was not considered a respectable profession whereas the scenario has completely turned on its head now and nursing is considered a very good profession. This is the scenario in the society. (C11-N)*

Participants from all hospitals and all professional groups perceived that dominance of medical professionals exists in Nepalese hospitals. This is felt strongly by nursing and allied health professionals from all types of hospitals. They stated that dominance of medical professionals exists because medical professionals are put on top of the

professional and organisational hierarchy due to their education, expertise and roles. Interestingly, medical professionals agreed that they are highly respected and recognised in Nepalese society and dominance of their professions to other professionals may be the reason of this. However, nursing professionals felt that the situation has gradually improved in recent years.

Medical professionals dominate overall service delivery aspects due to their roles, expertise, education and regulatory framework that gives them authority to deliver clinical services and they make clinical decisions in most of the clinical cases. It is apparent from the interviews that all health care professionals did not believe that they had an even degree of influence on the decision making process. Some participants (5 nursing and 10 medical professionals) felt that they were actively involved in decision making processes even though all participants stated that medical professionals make the clinical decisions. Three nursing professionals stated that they had limited involvement in the clinical decision making process. One nursing professional from the public hospital comments about the lack of participatory decision making:

> *Most of the decisions are dominated by doctors. ..... there is no participatory decision making and we or patients are not always involved. There is a daily morning conference; patient related team discussion mostly occurs here. (A1-N)*

The interview above suggests that medical professionals make clinical decisions without engaging other groups of health care professionals. Moreover, this suggests there was a lack of interprofessional team engagement in daily clinical team meetings. Another nurse from the public hospital experienced that medical professionals isolate them in decision making and feel that they do not have any power:

When the decision is often made, they do not consult with us (nursing professionals). .... in nursing I have little power to decide for patients and clinical care. We just have to follow them (doctors). (A4-N)

From the interviews above it can be observed that most of the clinical decisions are made by medical professionals with little or no help from other professionals. From the analysis of organisational structure and job descriptions of department heads and team leaders, it can be noted that medical professionals are the unit chiefs and team leaders in Nepalese hospitals and they make most of the management and clinical decisions. One nurse from the private hospital states:

The decision making is done by the unit chief. Whenever complications arise in the health issues of the patients, the doctors from the concerned departments are consulted. If there are no complications then the unit chief takes the decision himself. (B3-N)

Participants from the voluntary hospital also comment that team leaders make clinical decisions:

Decisions are made by team leader on the basis of ward round. Some of the doctors make the patient involved in the decision making process. (C1-N)

It is evidential from the interviews that medical professionals made decisions for service users and they took ownership of those decisions. One medical professional from the private hospital agrees and states:

We make decisions on the basis of clinical data. We have to find out which kind of patient he or she is and then we decide. (A7-M)

One medical professional commented that the discussion between health care professionals might be challenging and contradictory to each other. He stated that it is

difficult to make consensual decision in such a case and interprofessional care team leaders should be able to guide challenging discussions and seek to generate consensus across the interprofessional care team. One senior nurse stated that all health care professionals who are involved in decision making should be accountable for jointly agreed decisions and interprofessional care team leaders should hold professionals to account for agreed decisions and their actions. One allied health professional added that the consensual decision making in interprofessional working seems challenging as different professionals have different languages and different backgrounds. He further suggested that the health care organisations should facilitate the decision making process by developing interpersonal and team development tools, policies and guidance. Similarly, one medical professional suggests:

> *Hospital and management should organise induction for new starters and regular meetings for all colleagues. They also need to find ways to improve our interpersonal, professional and team skills for sound decision making for service users. This helps to improve mutual understanding, respect and trust. (B4-M)*

Most of the allied health professionals such as pathology assistants, radiographers, pharmacists stated that most of the time they did not have direct contact with service users. They stated that they worked behind the screen and did not have responsibilities for making decisions and consultation with service users. It is interesting to note that all allied health professionals from all hospitals mentioned that they did not have authority to make decisions for service users. One allied health professional from the public hospital states:

> *Here, after having observed the patient, the doctors make the decisions. We do not have chance to involve in making decisions for service users. (A6-A)*

Another allied health professional from the private hospital agrees:

> *We don't have any role in the decision making process. We also don't have any influence in the decision making process. (B6-A)*

Similarly, another allied health professional from the voluntary hospital states:

> *Mainly, the decisions for the patients are made by the team leaders but they also take our consent for decision making if the condition as such arises. The clinical decision is made by the team leader or in-charge himself. (C5-A)*

The statement above shows there is a scope for involving allied health and nursing professionals in making decisions for service users. It is surprising to note that all health care professionals in all hospitals thought that they could influence decision making process for service users. One doctor states:

> *As a counselling party, I influence the decision making process. (B3-M)*

One nurse from the private hospital states:

> *Some cases can be influenced by us but some can't. It all depends on the nature of the clinical problems and patients' need. (B11-N)*

Few participants (3 nursing and 3 allied health professionals) felt that they had the least influence in the health care team due to dominance of medical professionals in hospitals. They felt that their engagement and involvement in the health care team was limited. A nurse states:

> *It's difficult to influence the health care team and the decision making process in patient care because doctors are clinically competent and we (nurses) have limited clinical knowledge and expertise. Therefore, medical domination is seen*

openly and it is one of the reasons our influence is limited in decision making process. It depends on knowledge and experience you have with you. (A9-N)

An allied health professional from the public hospital experiences that his involvement in decision making is very limited. He states:

We (allied health professionals) see ourselves as an auxiliary profession and our role in the overall clinical treatment and patient care is very limited. Therefore, our involvement in clinical decision making is limited as compared to other professions. (A5-A)

Similar to this, one nurse mentions:

Patient care is mainly teamwork and we are all involved in one way or another, but all professions do not get involved to the same intensity as our (nursing professions) role is clearly defined only for patient care, not as medical or clinical care. This factor hinders our involvement in decision making. (C7-N)

The interviews above show that the engagement of nursing and allied health care professionals in the clinical decision making process is very limited and they have the least influence in the decision making process in comparison to the medical professionals, who make clinical decisions for service users.

Few participants (5 nursing, 4 allied health professionals and 4 medical professionals from 4 private, 6 public and 3 voluntary hospitals) highlighted that the level and intensity of interprofessional working and relationships is not the same for all cases. One medical professional suggests:

If a patient is suffering from multiple diseases and has many co-morbidities, he requires an intensive consultation, greater level of co-ordination, support and

advice. This means we need better communication and interaction between various health care professionals. (A2-M)

Six participants (2 nursing, 3 allied health professionals and 1 medical professional) felt that the intensity of interprofessional care depends on various factors, such as types of illness, associated co-morbidities, patient's social and health factors. Another medical professional points out:

It is obvious that the complex cases need more time, resources and interprofessional efforts to carry out assessment and to deliver health care. We need to involve many professionals for their care and need clinical inputs from various practitioners. (B5-M)

The more inter-dependency required to serve the service users, the greater the need for interprofessional care and collaborative practice among health care professionals (Hornby and Atkins, 2000). Five participants (2 nursing, 1 allied health professional and 2 medical professionals) felt that the make-up, break up and functioning of health care teams varies depending on the needs of the service users and the complexity and nature of the health issue define the tasks of health care professionals. Furthermore, they stated interprofessional working approaches and interprofessional relationships may vary based on the service users' needs and nature of services. Sometimes it may be a very simple approach or it could be more complex depending upon the nature of services to be offered. A nurse from the private hospital states:

A service user with a minor ailment admitted in the hospital may require a simple approach of interprofessional collaboration, whereas another elderly service user admitted with the injury and with many co-morbidities such as diabetes, glaucoma and depression may require a complex approach. (B10-N)

Findings from these interviews match with published literature. Alter and Hage (1993) and Leutz (2005) confirm that complex cases and complex patients need more co-ordinated assessment, time, integrated management and care plan.

Six participants (3 nursing, 2 allied health professionals and 1 medical professional) believed they were practising in an interprofessional care team in a collaborative way, simply because they all worked together with other health care professionals. In practice, they may simply be working within a group or team where each professional has agreed to use their expertise or skills in isolation or in a team to achieve a shared goal. One doctor from the voluntary hospital states:

> *We work together in a team on a daily basis, therefore we think we deliver interprofessional care, but we may not have common aims of delivering care and may not necessarily share expertise. ..... and we may not learn from each other. (C10-.M)*

Shared accountability, joint problem solving and shared decisions are characteristics of interprofessional working in teams (IPEC, 2011). Valuing working with other professional groups to deliver effective health services, being clear about one's own and others' roles and responsibilities and practising interprofessional communication contribute significantly to interprofessional collaboration. According to the Canadian Interprofessional Health Collaborative (2010), interprofessional collaboration is undertaken via a formal interprofessional team, that requires an understanding of team developmental dynamics and awareness of how organisational complexity influences collaborative practice.

Five participants (2 nursing, 2 allied health professionals and 1 medical professional) stated that interprofessional relationships depend on awareness of their own roles and

recognition of others' roles and responsibilities. One nurse from the private hospital comments:

> *First of all I need to check how well I work with others and what competencies and knowledge I have, whether I have played an effective role in my team rather than simply blaming others for not being effective in the team. If I cannot perform well, I cannot expect others to be performing well; therefore I have to think about myself and try to fit within the team according to my roles and responsibilities. (B3-N)*

One nurse from the public hospital agrees and states:

> *I see my profession in the middle of many other professions. I speak to many other professionals and I liaise with various teams including carers or families for effective delivery of services to patients. I have been doing this since I was a student nurse and will continue until I am in this profession. That's how we were taught and we are supposed to do. (A10-N*)

It suggests that health care professionals understand their roles in interprofessional care and the ways to get involved in the delivery of health care. An allied health professional from the voluntary hospital states:

> *I know the reason of my existence at work. I am here simply for patients and working with others. I am a part of a team and an organisation. Interprofessional care is part of my professional life. I think everyone in this department knows their team roles. Understanding other team members' expectations and performing own roles as per others expectations are equally important for me. (C5-A*)

The interview above suggests that knowing oneself is a starting point for knowing others and an individual member of a health care team can change himself or herself; but it is very difficult to change others. Therefore, health care professionals require being truthful about themselves and their professions; and are open to learn to enhance competencies for interprofessional care. Being honest with oneself is highlighted by a medical professional:

> *I have to be honest with myself to keep my professional standards and interprofessional relationships intact, only then I can think of others to encourage them in order to be an active member of the team. Some people just keep their appearances in the interprofessional team, which I think does not help to achieve collaborative practices. (A11-M)*

Understanding each other's skills, roles and commitments are ways to keep all health care professionals integrated into an interprofessional care team. This also helps to keep good relations with other health care professionals. One allied health professional comments:

> *I feel I am a part of the team simply because I feel I am valued and I equally understand others skills and roles. I expect others to do the same for me. (C9-A*)

Without trust, interprofessional working is not possible to happen in practice (Mayer et al, 1995). Few participants (2 nursing and 2 allied health professional) stated that the lack of mutual trust and respect is reported so intense that even nurses, doctors and allied health professionals do not get involved in the same training at the same time. As one allied health professional puts it:

> *The hospital does not organise in-house training for us. When there is training, we hardly mix with other professionals. I feel other professionals do not want to*

involve us in the training. It shows other professionals' attitude towards us and toward interprofessional working. (B6-A)

Participants experienced that interprofessional relationships flourish when health care professionals are honest, recognise themselves and have mutual trust and respect. Participants viewed that mature, honest and open interprofessional working relationships among and between health care professionals are vital for the effective delivery of health services. They further emphasised that the nature of interprofessional working relationships depends on the individual needs of service users, care planning and management.

To conclude, participants felt that medical professionals dominate overall service delivery aspects and they make clinical decisions for service users in Nepalese hospitals. They mentioned that the main reasons for dominance of medical professionals in Nepalese hospitals are hierarchy, recognition, education, training and roles of medical professionals. Some participants felt that it creates boundaries and divisions between different health care professionals. On a positive note, nursing professionals stated that the situation of dominance of medical professionals in Nepalese hospitals has gradually improved in recent years.

Nursing and allied health professionals stated that they have limited involvement and the least influence in clinical decision making and they highlighted that medical professionals make clinical decisions for service users in Nepalese hospitals. Medical professionals agree on what other professionals say. Participants felt that the level of intensity of interprofessional working and relationships is not the same in all cases. They stated that interprofessional relationships between health care professionals depend on awareness of their own roles and recognition of others' roles and responsibilities.

6.4 Health Care Professionals' Identity, Boundaries and Autonomy

Recognition, professional autonomy, interdependence and professional boundaries were key points of discussion during the interviews. This theme is divided into three different sub-themes – professional identity, boundaries and autonomy.

Participants expressed their opinions regarding recognition from other health care professionals and the public. Nursing professionals have mixed experiences regarding professional identity from other professionals. Some stated their profession is well recognised from other health care professionals and the public. One nurse from the public hospital states:

> *I find my identity recognised by my colleagues and the public. I do not find my profession equivalent to other professions like medicine. In the view of other's profession, individually they recognise me as competent and skilled I think. (A1-N)*

Health care professionals work together in many aspects of clinical care and they use their expertise, skills and competencies in a specific area of clinical science. There was a positive feeling and a great sense of recognising each other's contribution even though they felt they had a separate identity. One nurse from the public hospital states:

> *As a nurse, we have a separate identity, it's a separate profession. We have our own knowledge and skill. As a whole I am satisfied with the professional identity. Though there is little recognition from the public, the professionals who work with us in the hospital recognise and respect our profession. (A4-N)*

Nursing professionals from the private hospitals have slightly different experiences than the public hospital. A nurse from the private hospital noticed her profession was not well respected by other professionals and the public. She comments:

I don't think the nursing profession is as respected as it should be. From the public's point of view, nursing is not a dignified profession. Nurses as well as doctors contribute equally to the patient's health care. However, our contribution to the cause does not get any words of appreciation, rather doctors get all the credit. (B8-N)

Two nurses from the private hospital commented that the nursing profession is not well recognised in comparison to other health care professionals. A nurse from a private hospital states:

The nursing profession is not as recognised as it should be by other professions. This exists not only here but all over the country. (B3-N)

Two participants (1 nursing and 1 allied health professional) believed that professional identity is not the same as personal identity. An allied health professional separated himself from his professional group. He stated he was recognised well, but not his profession. He states:

Personally I think I have a good identity and recognition. But as a profession, the laboratory professionals are regarded as the most dominated department. We are not recognised well by other health care professionals. However, generally the public and patients recognise us very well. (A3-A)

The majority of the nurses (in total, 9 out of 15 nurses; i.e. 60% of the nurses) hold the opinion that the situation has now improved and they are happy with the way their identity is recognised and that they are valued in the interprofessional care team. A nurse from the public hospital states:

Nowadays, I have found my identity recognised. I can proudly say that I am a nurse. Doctors used to dominate us as an auxiliary profession but nowadays it is recognised well. (A9-N)

Another nurse from the private hospital comments:

I feel proud to be a nurse. As a nurse, I have been able to provide for my family and feel pride in my profession. (B10-N)

A nurse from the voluntary hospital agrees and states:

During the beginning of my practice, nursing was not considered a respectable profession whereas the scenario has completely turned on its head and nursing is considered a very good profession now. This is the scenario in the society. (C11-N)

Few participants (3 allied health professionals) also experienced that their profession is now gradually recognised by the public and the other professionals. For example, an allied health professional agrees and adds:

Professional identity of an optometric has been increasing nowadays. We have gained very good reputation in public as well as among different professionals. (C8-A)

Five allied health care professionals (2 from the public, 1 from the private and 2 from the voluntary hospitals) felt that their profession is well recognised in the view of other health care professionals, but they are not well valued by the public. They felt that their profession was not well valued and respected compared to other professions in health care. One allied health professional from the private hospital comments:

In the hospital my profession is recognised but out of the hospital people know very little about my profession. We have to depend on the decision of the doctors. (A3-A)

Another allied health professional felt his profession was in the shadow of the medical profession. However, he expresses his satisfaction being an allied health professional and states:

In our country, our profession is not regarded as much. In this country, I think that only doctors are respected. Comparing today's scenario to the past, we can say that in totality our profession is respected by other professions. I am proud and feel happy in my profession. (C8-A)

Six nurses and 5 allied health professionals observed that the attraction for nursing and allied health professionals has tremendously increased in recent years in Nepal. This is evidenced by the increased number of educational organisations established in the last decade to offer courses for these professions and thousands of professionals undertaking courses related to nursing and allied health professionals. There were two hundred and twenty-eight nursing colleges for nursing education registered with Nepal Nursing Council (Nepal Nursing Council, 2014) and one hundred and twenty-two colleges registered with Nepal Health Professionals Council for allied health professionals in Nepal (Nepal Health Professionals Council, 2014).

As pointed out earlier in this section, nursing and allied health professionals commented that medical professionals were highly recognised and valued by the public and other health care professionals. Moreover, all medical professionals believed their profession was well respected, recognised, valued and understood by other health care professionals and the public. One medical professional from the private hospital states:

Doctors are respected by all the people. Other professions respect, recognise and regard us too. (B4-M)

To summarise, the interviews suggest that the medical profession is more recognised than nursing and allied health professions. This is the case in all hospitals under study. Nursing and allied health professionals experienced that their professions were shadowed by the medical profession. However, nurses and allied health professionals noticed that the situation has now changed and they are now more recognised than in the earlier days of their professions in Nepal. These observations apply for all hospitals under study. Professional identity and autonomy are linked in terms of managing professions. Recognition by other professionals and the public is important to set authority, power and control for the self management of any professions.

In terms of autonomy, thirteen participants (6 nursing, 4 medical and 3 allied health professionals) stated that their profession was not autonomous as they depend on medical professionals and other health care professionals. Few participants (3 nursing, 2 medical and 2 allied health professionals) linked autonomy with independence and the way they perform their task without any influence or control from other professionals within the health care context. One allied health professional from the private hospital comments:

I still cannot make independent judgement. From a clinical aspect I am dependent on doctors and other professions. Therefore, I do not think that my profession is autonomous. (A3-A)

Another allied health professional from the public hospital's experience is similar to the nursing professional as she states:

There is no professional autonomy for us (allied health professionals), we work together but in a parallel way and are reliant on other colleagues (health care

professionals), especially the medical professionals. Therefore, I feel we are always dominated by them. (A6-A)

Nurses stated various reasons for not being autonomous in their profession. One nurse states that her profession is an auxiliary to medical profession:

I don't think that my profession is autonomous; the reason for this is, my profession is considered auxiliary to medical profession. Moreover, it is a female's profession and there is a different perception for only female profession in our society. (A4-N)

Another nurse from the private hospital stated that nurses are managed and controlled by medical professionals in the hospital. She states:

I don't think nurses are autonomous. There is always another director (Medical Director) who controls all the nurses. I don't think our autonomy is fully respected. (B1-N)

One nurse adds that nursing professionals are dependent on medical professionals; therefore they do not consider themselves autonomous:

Our profession is dependent on the doctors and hence is not autonomous. I think that our autonomy is not respected by other professions at times. Sometimes we know what is wrong and what is right, but the doctors don't respect our decision and we are overstepped. (B12-N)

Fifteen participants (8 medical, 3 nursing and 4 allied health professionals) stated that their profession is autonomous. In comparison to other professionals, the medical professionals have quite a strong view regarding the professional autonomy. It is interesting to note that most of the medical professionals stated that their profession is autonomous and independent. One doctor from the public hospital states:

My profession is autonomous. Despite this, our work is always in the group as the patients who come to our department need many health professions. I think our professional autonomy is respected by other professionals. (A11-M)

Another medical professional from the voluntary hospital agrees and states that the medical professional is autonomous:

I have found myself respected in the team. My profession is autonomous and it is respected by other professions. And there are no overlapping roles among the staffs. I think myself as independent practitioner. (C10-M)

One allied health professional from the public hospital states:

... they (nursing professionals) really appreciate our profession but while working with senior doctors our contribution keeps in the shadow. Nowadays doctors say public health expert and anthropologists also like them to say public health experts. While talking about opportunity, doctors got scholarships for overseas study, but we hardly get those opportunities. My profession is really autonomous; we have an opportunity for leading the team. Our autonomy is respected by other professions. I think I am an independent practitioner. (A12-A)

Interestingly, a medical professional raised an issue of 'fear factor'. He states his profession is not autonomous and not independent:

The medical profession is not an autonomous profession. We are bound by a fear of doing harm. The fear factor indicates that we are being too careful while judging the condition of the patients. We are very careful and as a result the patient has to suffer. So, I am not independent. Our professional autonomy is not respected by other professions. I concentrate more on not making mistakes than

on doing the right thing. So, nowadays doctors are working towards not trying to make mistakes. (B5-M)

It is interesting to note that three different health care professionals have different opinions about professional autonomy and interprofessional working. Some of the nursing and allied health professionals stated that their profession was autonomous, whereas some others think that their profession was not autonomous. The vast majority of medical professionals experienced that their profession was autonomous. These findings are similar across three different types of hospitals. It is surprising to note that different professions did not get the same level of recognition by other professions. It varies with the professional autonomy, respect, roles and responsibilities.

Health care professionals have to play different roles and their tasks are defined by different factors such as expectations of service users, regulations, technologies, education and learning and shaped by interprofessional relationships formed over time (Nancarrow and Borthwick, 2005). All medical professionals from all hospitals experienced that their professional boundary is protected and they are superior to other professionals. One medical professional states:

Nobody questions and nobody interferes. Interfering is bad but asking questions is good. There is no situation of inclusion and exclusion. (A2-M)

This shows that there is no one to challenge medical professionals as other professionals and the public highly respect, value and recognise their professional expertise. Medical professionals experienced that their professional boundary is untouched by others.

On the other hand, 8 nurses (3 from the pubic, 3 from the private and 2 from the voluntary hospitals) stated that they work within the limited boundary of the nursing

profession. They felt overlapping of roles occurs with the roles of other professionals while providing patient care. One nurse comments:

> *Sometimes we know things but we can't prescribe. For example, if a patient has a fever but we cannot give them a medicine until and unless the doctor prescribes it. Overlapping often happens, for example the work of physio is sometimes done by a nurse too. (A8-N)*

It shows that participants felt their professional boundary is set by skills, competencies and regulations as well. Another nurse agrees and states overlapping of roles between different health care professionals affects clinical care:

> *When it comes to nursing care, I don't think there are any boundaries but when it comes to the clinical decision making process, we can't carry out any medical processes by ourselves. ..... if there is overlapping of roles of different professionals then the treatment of the patients can be hampered, while carrying out treatment errors can be made. (B8-N)*

The majority of the allied health professionals (7 out of 10 allied health professionals) also felt that they are limited within their profession and experienced interference from other professionals. One allied health professional from the public hospital comments:

> *As our profession emphasises on exercise, we have limitation like we cannot prescribe the medications. Other professions sometimes interfere with ours. Overlapping sometimes affects negatively on the care of patients. (A5-A)*

Another allied health professional from the voluntary hospital agrees and comments:

> *There are certain boundaries for all professionals and we work within our professional boundaries which are defined by our knowledge, skills, capabilities and professional regulations. As I said before, there is a certain level of*

overlapping. But after reaching a certain level, that stops and then there is clear distinction. Due to the overlapping, the quality of care degrades on the patient. (C7-A)

Seven participants (2 nursing, 3 medical and 2 allied health professionals) stated that overlapping caused conflicts. For example, one allied health professional from the voluntary hospital states:

Conflicts happen because of overlapping of roles between health care professionals. Whenever my profession has to perform some procedures but another profession does it and it hampers the health of the patient then conflict arises. Similarly, if I think that I have done my work correctly but higher levels of doctors don't recognise it then conflicts can arise because we think that we know better than those in that particular category. (C7-A)

To conclude, medical professionals experienced that their professional boundary was defined and protected; whereas nursing and allied health professionals commented that they were limited within the set professional boundaries. From the interviews above, it is evident that health care professionals experienced encroachment and overlapping of roles. They also experienced conflicts due to unclear professional boundaries, overlapping roles and encroachment from other professionals.

The interviews above show that medical professionals are well respected, recognised and valued; they are autonomous and their professional boundaries are well protected. Nursing and allied health professionals shared mixed experiences regarding professional identity and autonomy; and they felt that they have limited boundaries and experienced interferences from other health care professionals. These concluding remarks are true for all types of hospitals under study.

6.5 Importance of Organisational Support and Structures for Interprofessional Working

One important theme that arises from the analysis is the importance of organisational support and structures for interprofessional working. Participants highlighted the importance of organisational support for interprofessional working in health care. They further emphasised the importance of clinical leadership for interprofessional working, lack of organisational support for training and development, importance of developing and implementing organisational policies for interprofessional working and motivating health care professionals for achieving common goals for interprofessional care teams. There are three sub-themes under this heading - clinical leadership; policies and guidance; and interprofessional training, education and competencies for interprofessional working.

Participants felt that the health care organisation defines the roles of clinical leaders and delegates authority to ensure safe and effective delivery of health services. Therefore, they felt that organisational support was essential for the development of clinical leadership and for successful interprofessional working. Most of the participants (9 nursing, 7 medical and 6 allied health professionals; 7 from the public, 8 from the private and 7 from the voluntary hospitals) felt that the importance of an interprofessional care team leader is becoming increasingly evident for improving delivery of health services. One nurse from the public hospital states:

> *I have seen my team leader, a medical professional, has resolved conflicts between two different professionals and driven the team for achieving common goals of our team. He has also established processes for resolving conflict. (A4-N)*

Most of the participants (6 medical, 7 nursing and 5 allied health professionals) believed that the initiatives taken by a team leader of interprofessional care team helped to enhance skills and competencies of health care professionals. One allied health professional from the voluntary hospital states:

> *I feel my team in-charge (medical professional) takes necessary steps to facilitate interprofessional working. He takes actions to promote interprofessional working across the hospital through team meetings .... I think these initiatives help us to improve interprofessional relationships between colleagues and to enhance our knowledge and skills required for interprofessional working. (C6-A)*

Participants in all hospitals had a common view about who leads the interprofessional care team. All professionals from all hospitals stated that medical professionals lead the team and felt that team leaders were supportive. One nurse states that a medical professional leads her team and highlights the need to improve the way her team leader leads the team:

> *For now the doctors lead the team. ..... They support us and they are competent but there are still things to improve. (A1-N)*

Twenty one participants (8 nursing, 8 medical and 5 allied health professionals; 4 from the public, 11 from the private and 6 from the voluntary hospitals) experienced that their team leaders were supportive to interprofessional care and they felt that some of the clinical leaders were competent. They felt it was encouraging and positive for successful interprofessional working. An allied health professional from the public hospital states:

> *All the senior doctors are the leaders. They support us in patient care. Sometimes they thank me for doing well while helping them in treating patients. Sometimes,*

they do not appreciate us. Some of the doctors are competent and skilled. We have participatory leadership. In my case they have good attitudes towards me. (A5-A)

One nurse from the private hospital had similar experience. She adds:

Doctors are the leader of the interprofessional team. We are also supported and encouraged by the team leader. I think that the team leader is competent as well as empowered as it is an essential trait for being a leader. (B10-N)

Medical professionals agreed on what the nursing and allied health professionals experienced. A medical professional from the voluntary hospital states:

Here, the unit chief (medical professional) leads the team. The team leader supports and encourages us for the proper delivery of health care. The leader is competent and empowered. The attitude of the leader is found to be positive. (C3-M)

In summary, all participants from all hospitals highlighted the importance of an interprofessional team leader for interprofessional working and concluded that medical professionals lead the interprofessional care team and they felt the team leaders were supportive for interprofessional working.

From the interviews, it is noted that there were no such ground rules, organisational policies or protocols for interprofessional working and decision making. Five participants (2 nursing, 2 medical and 1 allied health professionals) acknowledged that health care professionals need to have organisational policies, protocols or guidance rules for interprofessional decision making and working, to avoid duplication and to bring clarity in roles. The lack of policies or protocols can be seen in the following statements from various health care professionals.

One medical professional pointed out that lack of organisational policies for interprofessional working is not helpful in order to deliver interprofessional care:

> *We have no practice to set up rules for interprofessional working to make sound and appropriate decisions for the delivery of interprofessional care. This does not help to improve interprofessional working relations. (A7-M)*

Another medical professional from the public hospital points out that they do not have any protocols:

> *There is no written protocol in the hospital (for interprofessional working) however we have a mechanism where the doctors write on the form. (A2-M)*

One nurse from the private hospital stated that there were inconsistent approaches due to the lack of protocols for interprofessional working. She states:

> *There are no written protocols for interprofessional working in this hospital. The rules are used according to the situation. (B11-N)*

One allied health professional from the voluntary hospital comments that there was no guidance or protocols for interprofessional working at any levels. She adds:

> *I have never seen any guidance or protocols for interprofessional working, not only in this hospital, but also in other hospitals, at national or regional levels. (C6-A)*

In practice, those rules may be in a formal format or informally agreed practices between health care professionals. One nurse comments:

> *We have team meetings and departmental meetings. We mainly discuss clinical cases, operational issues and some other non-clinical things. Therefore, the objectives of those meetings are different to the shared goals of interprofessional*

working. I would say there is no means to develop common platforms for shared decision making. (B8-N)

From the analysis of hospital documents, strategies and policies of participating hospitals, it was noted that the hospitals did not have guidance for interprofessional working. Moreover, from the interviews it becomes evident that participants believed there were no resources or practices to provide administrative support to interprofessional team meetings and conferences. It may be due to lack of funding for such a provision or lack of enthusiasm from the hospital management or leadership. Martin-Rodriguez et al (2005) assert that health care professionals require administrative support to develop and implement interprofessional working effectively. During the research, job descriptions of ward managers, in-charges and department heads were reviewed. The job descriptions of hospital managers did not have any components or roles specified for interprofessional working or collaborative practice between various health care professionals. It was observed from the hospital statistics that there were not enough managers and administrative posts in the private hospital under study to provide administrative support to health care teams for interprofessional working. D'Armour et al (1999) confirm that lack of managers has a negative effect on interprofessional working.

From the review of the organisational structures and policies of the three hospitals in Nepal, it is concluded that the organisation structures of all three hospitals appeared hierarchical. Nepalese hospitals are run and operated on traditional hierarchical structures for power sharing, decision making and communication. From the interviews with department heads and senior management, it appeared that top management hold the ultimate power and they had greater decision making authority. Moreover, they stated that the top management delegated limited authority or power to department heads, who were placed beneath them in the organisational structure. They experienced that there was

little scope to cross the boundaries of one department to another for interprofessional working due to hierarchical structures. In hierarchical structures, horizontal communication across various departments is not efficient and the less powerful team hesitant to communicate the information upwards (Anderson and Brown, 2010). Henneman et al (1995) suggest that horizontal organisation structures rather than hierarchical structures are preferred for effective interprofessional working.

Participants (5 nursing, 7 medical and 3 allied health professionals; 4 from the public, 6 from the private and 5 from the voluntary hospital) highlighted a lack of resources and time for interprofessional working. One medical professional stated that he was busy all the time and he hardly had time to interact and discuss issues related to interprofessional working on his own time. By its nature, interprofessional working requires time and resources to share information, to discuss interprofessional issues and to develop sound relationships between health care professionals (Mariano, 1989). From the observation of physical layout of the hospital and clinical areas in the three hospitals, there are no common areas or meeting rooms in clinical areas to discuss interprofessional issues and organise team meetings. Mariano asserts that physical proximity and sharing clinical spaces reduce professional territoriality. Linkdeke and Block (1998) confirm that physical closeness and sharing clinical spaces facilitate interprofessional working and reduce conflicts.

It is concluded that participating hospitals do not have guidance, policies, protocols and procedures for interprofessional working practices between health care professionals. Some participants stated that they need to have guidance and policies for interprofessional working to avoid duplication and to enhance clarity in roles. Participants also highlighted lack of resources and support for interprofessional working in Nepalese hospitals.

Participants (9 nursing, 2 medical and 6 allied health professionals; 6 from the public, 7 from the private and 4 from the voluntary hospitals) raised concerns about the lack of training and education for interprofessional working. They highlighted the lack of organisational support and initiatives for organising training for interprofessional working. They further stated that interprofessional education and learning is a pre-condition for many other attributes in interprofessional working such as open and effective communication, role awareness, mutual respect, trust, counselling and mentoring. Clark (2011) confirms that there is a linkage between interprofessional education delivered in university and interprofessional working in health care organisations. Clark asserts that interprofessional education helps practitioners to recognise their limitations and teaches skills for mutual trust and respect, which is beneficial to solving patients' problems and to being a better team player.

Most of the participants (9 nursing, 7 medical and 7 allied health professionals) highlighted that there was no interaction during their university life between health care professionals for interprofessional care. They commented on their lack of interactions with other professionals. One medical professional from the private hospital states:

> *There was no training on interprofessional working in my graduation course. I was trained on clinical skills and very few aspects of communication. I was not sure about the nursing roles, responsibilities and their involvement for interprofessional care when I was a medical student. (B14-M)*

Nursing professionals shared similar experiences. One nurse from the voluntary hospital states:

> *I never had a chance to learn interprofessional skills at University. I used to work with other professionals as a student nurse, but there was hardly any interaction*

with medical and allied health professionals for interprofessional working. (C11-N)

Similarly, allied health professionals felt that they were isolated from the mainstream of health services. One allied health professional from the public hospital states:

I felt I was working with only pharmacy team. We did not have much contact with clinicians (medical professionals) and nursing groups at university. Even in today's scenario as a practitioner, I am contacted and consulted when medical or nursing teams need any clarification or information. (A3-A)

According to some participants (3 nursing and 2 allied health professionals), the lack of knowledge about the roles, skills and competencies of other professionals has implications on interprofessional practices between health care professionals. Health care professionals should be aware of each others' roles, professional skills and competencies to hand over tasks and to carry out procedures with the help of other professionals. Different professional groups have professionals with different grades. One medical professional commented that each grade or level of professionals within one professional group has different roles, set of skills and competencies. Therefore, it is not easy to compare different professions or one sub-group with another group of professionals. One medical professional comments:

I find senior nurses are more knowledgeable on interprofessional working and they have more confidence, knowledge and expertise to deal with us and patients. (A7-M)

A nurse expresses almost the same opinion:

Senior consultants know exactly what they are doing and how to deliver interprofessional care to patients. They are very busy and they do not have

enough time to explain everything to us and the patients. Some of them do not even think they have to play an active role for interprofessional working due to their poor attitude. (A9-N)

This shows that these senior professionals may have knowledge and skills, but may not be able to communicate those to colleagues and service users due to various reasons. One nurse stated that commitment, dedication and positive attitudes of health care professionals were equally important to deliver interprofessional working in hospitals. Moreover, one medical professional believed that each group of professionals has different sub-specialties and they need slightly different approaches and skills to deal with interprofessional working priorities. Similarly, one nurse supervisor from the private hospital states:

Critical care department requires intensive clinical efforts and they deal with different specialties. But, they don't deal much with patients as compared to other specialties. Sometimes they deal with more emotional issues within the critical care department. Therefore, level of communication and interaction required in different specialties within the nursing care is slightly different even though principles of interprofessional care and nursing practices are almost the same. (B1-N)

At what stage health care professionals start interprofessional care training and their engagement for interprofessional working is also a point to consider. Few participants (2 nursing, 3 medical and 1 allied health professional) felt that it is obviously better if they receive training on interprofessional working at an early stage of their student life or career. They stated that this helped them develop skills at an early stage and practise interprofessional working in clinical settings for effective delivery of health care. One medical professional from the private hospital comments:

I feel collaborative practice is a part of our professional life. This is the truth. Better we know each other in terms of interprofessional skills and competencies, better the clinical practice for patients. Therefore, it should be introduced at an early stage of university education so that everyone can develop skills for interprofessional working during student life and can enhance skills throughout the professional career. (B13-M)

One medical professional stated that joint training and courses for all groups of heath care professionals on some aspects of clinical care and interprofessional working help to acquire and enhance interprofessional skills and competencies. He further suggested that this could be done in various forms such as workshops, short courses, in-house training in hospitals and online courses. Most of the participants (7 nursing, 7 medical and 5 allied health professionals) acknowledged that they learnt skills for interprofessional working at their workplace as 'learning by doing'. In this case, necessary support is required to all health care professionals from their organisations. One nurse from the private hospital states:

I think I am competent and capable. These skills are acquired over a period of time. This starts from the preliminary schools and then throughout college. After joining nursing, we have to work with a team. As a nurse, I think one must have capability. It is not necessary that each and everyone have the same qualities and capabilities. (B1-N)

One allied health professional from the voluntary hospital states:

Skills including communication skills and sharing are vital for team collaboration. I think that I have these skills and I can communicate effectively. I have learned these skills here itself while working. I don't think that special skills

can be acquired by studying books. The formal courses might be conducted here but I have no idea regarding such things. (C6-A)

It is surprising to note that participants felt that they were competent and capable of delivering interprofessional care and clinical care to service users despite the lack of training to health care professionals on interprofessional working. The skills, knowledge and organisational structures are the core capabilities for interprofessional working along with the competency for individual health care professional (CIHC, 2010). In this scenario, health care professionals are required to be competent to meet guidance or protocols for interprofessional working and to work within the organisational boundaries for the defined roles. One nurse felt that they also learnt from each other by working together and sharing knowledge and expertise for the delivery of effective health services. Another nurse from the voluntary hospital states:

Interprofessional working is an opportunity for professional development as it breaks professional silos and helps to achieve holistic care delivery by integrating services. (C2-N)

From the interviews, it is evident that participants thought they learnt interprofessional skills at work, but that they did not have the chance to learn proper skills and competencies at universities or they did not have any formal training at their workplace. One doctor from the public hospital states:

We don't have any training opportunities to develop skills on interprofessional working. We have acquired those skills at work. It is mainly learning by doing. There are no courses in the universities on this subject. I don't have any training opportunities for skill development here in this hospital. But we are acquiring this skill by doing it. (A2-M)

Reel and Hutchings (2007) assert that willingness to participate and a high level of motivation are two pre-requisites for interprofessional care teams to function well together. One nurse felt that good team members always keep shared goals and optimal desired outcomes in their mind and effective team members give each other encouragement, vocalise their support to each other and compliment a team member on their success. According to one medical professional, that was how heath care professionals wanted to keep each other informed and respect each other. One nurse from the public hospital states:

> *In order to achieve the shared goal of effective delivery of health services through interprofessional collaboration, each health care professional needs to relate to other health care professionals. Therefore, health care professionals should be familiar with the skills for interprofessional relationship building, so that health care professionals work together to deliver the desired health outcomes. (A4-N)*

Participants mention various skills they need to have for interprofessional working.

> *I think I am competent and skilled even though I have never got training for these sorts of things. I have habituated the skills. I think we need interprofessional communication skills because as a lab technician we have never got the responsibility to make decisions, so it is our communication skills that could help us to reach to the decision making level. Other professions have not received any training regarding interprofessional working and some of them have good communication skill whereas some of them don't. (A6-A)*
>
> *Sharing, questioning, helping, communication, decision making are the skills needed for good team work. I think I have the skills and I learnt them whilst*

working here. Yes, I think I am competent in dealing with other professions and other professionals are also competent (A10-N).

The most important is orientation. This makes communication easy between the professionals. Or else, the communication becomes lateral and the professionals don't understand each other. I think that I have these skills as required and also have got room to improve my skills. I think that I have learned these skills over time as I gained more and more experience in my field of work. I haven't taken any formal training to learn these skills. (B4-M)

Education, training, communication skills and leadership skills are the skills learned and necessary to have for interprofessional working. I think that I have got these skills. I don't think that everyone has the skills required for proper communication. (C11-N)

Overall, one should understand about his profession properly. He should have proper exposure to the latest advancements and should also try to provide that knowledge to his team members. I think that some have got the skills required but some have to learn these over the course of time. I don't think that there are training programmes conducted here in Nepal for the development of teamwork skills. (C4-M)

To conclude, participants mentioned various skills and competencies required for interprofessional working. The most frequently mentioned skills and competencies for interprofessional working in health care are communication skills, interactional skills, professional knowledge and skills, diplomacy, decision making, leadership, working with others, sharing, counselling, listening, willingness to participate, ability to support, mutual respect, trust, helping attitude, tactical thinking and questioning.

In summary, participants from all professional groups from all hospitals mentioned that there was no provision for training and education in Nepal for interprofessional working. They expressed concerns at lack of policies and guidance for interprofessional working in Nepalese hospitals and emphasised the importance of organisational support for developing such policies and training. It is interesting to note that participants felt competent in dealing with others despite the lack of training and education on interprofessional working. Participants stated that they learnt interprofessional skills at work by 'learning by doing'. They felt health care organisations need to do more by organising training to enhance their skills and competencies for interprofessional working.

6.6 Different Cultures between Various Professions

One of the consistent themes from the interviews is cultural differences between health care professionals in Nepalese hospitals. Participants felt that there were varieties of different skills, approaches, norms, values and beliefs in interprofessional care teams. They further pointed out that there was also co-existence of different health care professionals within the interprofessional care team in Nepalese hospitals. This is highlighted by all groups of health care professionals in all hospitals. Participants mentioned various reasons for the differences in professional culture between health care professionals. Participants understood the value of respecting the culture of other professionals in health care. A doctor from the public hospital highlights the importance of understanding others culture and comments:

> *I think culture and attitude are very important to patients and doctors. It determines the behaviour to the patient. The sense of feeling to the doctors that other people do not have the same feeling. (A2-M)*

The vast majority of the participants (13 nursing, 8 medical and 8 allied health professionals) stated that different health care professionals had different cultures, values and beliefs. One nurse from the public hospital states:

> *Professionals from different fields have different cultures, values, beliefs and attitude towards interprofessional working. They have to work to find out what kind of a role they have to play. (A7-N)*

Another nurse from the private hospital comments that she experiences cultural diversity between various professions due to education, background and knowledge:

> *There is a difference in professional culture. Due to the difference in education, background and knowledge between the professions, there exists difference in the culture. (B12-N)*

Another nurse from the private hospital gave an example to illustrate why nurses and doctors experience differences in culture:

> *We as nurses believe that the patient not only needs medical but also psychological treatment. But the doctors only focus on the medical part, whereas we (nurses) focus on care and emotional part as well. This is the major difference in culture of these professions. (B3-N)*

One medical professional from the voluntary hospital gave a simple example to explain the differences in professional culture between nursing and medical professionals:

> *There is a difference in the culture between the health professions. We only concentrate on medical history but the nurses spend more time with the patients and also concentrate on the family history as well as other things. There is a different level of understanding in different levels of professions. (C3-M)*

One allied health professional from the voluntary hospital explained the roles of various professionals in patient care and how a patient is seen by various professionals from their perspectives:

> *The culture definitely differs according to the professions. I as a radiographer, try to expose the patient to as less radiation as possible. For example, if a pregnant patient comes for X-rays, more amount of radiation is adjusted according to that so that it doesn't affect the patient as well as her baby. Similarly, the nurses try to comfort the patients and the doctors take care of the medical field according to their field of work. Hence, it differs. (C6-A)*

One nurse from the voluntary hospital agrees and adds:

> *We as nurses, look after the safety and comfort of the patients whereas the doctors take more focus in treatment. Hence, the professional culture differs between the professions. (C11-N)*

Another allied health professional from the public hospital shares her experiences by giving a live example:

> *Public health personnel have a down to earth personality; I think they are rarely arrogant. We accept as a person to knock the door of patient. That is the basic culture. What we have learnt is sympathy and empathy. Ethics and patients' rights are the aspects on which we are specially trained. (A12-A)*

However, one nurse states there is no difference in professional culture when it comes to patient care:

> *I don't think there is cultural difference between the professions. When it comes to the patient's health matter, everything else is brushed aside. (B1-N)*

One medical professional perceived that health care professionals who understand cultural diversity in health care show attitude and behaviours facilitating them to successfully work with other professionals with different backgrounds. According to one nursing professional, this is the way health care professionals help to deliver a health service that meets quality standards and satisfies the need of service users and all stakeholders. The statement above shows that they are there for patient care and they take cultural diversity and the preference of health care professionals into account. Many participants (5 nursing, 4 medical and 4 allied health professionals) stated that cultural differences were good for health care professionals and patients. They stated that the differences in professional cultures amongst health care professionals create a favourable environment by respecting each other's territory, competencies and roles. One medical professional from the public hospital states:

> *We have a diverse working and professional culture. It helps to fill a gap in competency and skills by utilising talents and attributes of various groups of people. It also fills gaps in clinical skills. (A7-M)*

Another doctor from the private hospital comments:

> *Professional culture should exist in my view. If everyone is the same then nothing new can be learned. If different people view the same thing differently then development can take place. So, it can be taken in a positive point of view. (B2-M)*

One allied health professional comments that cultural differences should not be a problem:

> *I think that different professions have different cultures and their values and beliefs vary with the individual. I do not think there is a problem with this. (B7-A)*

However, five participants (2 nursing, 1 medical and 2 allied health professionals) experienced different negative consequences of cultural differences between different health care professionals, if it is not managed properly. For instance, one medical professional states that cultural difference causes conflicts and misunderstanding:

> *Professional cultural difference causes misunderstanding and leads to conflict. Patients want the doctor and nurses in front of them. Different professions should understand other professions. But the situation is going to be positive. (A13-M)*

Cultural differences from gender perspectives were highlighted by few participants (3 nursing and 2 medical professionals). For instance, one medical professional from the private hospital comments:

> *Regarding culture, the only culture difference I feel is between the genders rather than the whole profession. Nursing is a profession which is dominated by female and the doctor's profession include both male and female. This is the only difference in culture according to my point of view. (B13-M)*

Nursing is only a female's profession in Nepal and this is very unique in terms of working culture. Few nursing participants (3 nursing professionals) perceived that nurses are treated differently at workplace. One nurse states:

> *I feel we (nurses) have different problems and we have different working cultures as well. Sometimes we are seen just as an 'assistant' to doctors and as 'females' working as an 'auxiliary' to doctors. (A9-N)*

One nurse from the private hospital feels that they are separated due to their educational system and regulations set by the regulatory bodies:

> *Males are not eligible for the nursing courses in Nepal. We are seen differently from the beginning of university life. It is mainly due to the education system in*

Nepal. Therefore, other professionals also treat us differently at the work place. (B8-N)

One nursing professional indicated that challenging another's view is sometimes observed in interprofessional care between health care professionals. However, few participants (5 nursing and 3 allied health professionals) stated that they do not usually challenge views of medical professionals due to various reasons. One nurse comments:

I usually do not challenge doctors. I feel this is a kind of professional culture here. There are genuine reasons for this. Firstly, our (nurses) approach to patient care is different from doctors. And, I do not have that level of skills and knowledge to evaluate their works. (B11-N)

However, such practice may not be viewed as appropriate in interprofessional care due to the fact that each group of health care professionals' offer their own particular contribution from their perspectives and expertise. One medical professional asserts:

I offer my advice and treatment from a clinical viewpoint. If someone from another profession does not think that I am doing well to a patient, I expect to challenge my viewpoint. This helps me to learn from others and helps patients by improving their care. I think we complement each other and this is the right professional culture. (C4-M)

In summary, it can be concluded that participants acknowledge, appreciate and understand differences in professional culture between different professionals and they describe the reasons for such differences. As stated by the participants, the main reasons for cultures are differences in education, training, roles and their background. Most of the participants felt that it was beneficial to have diversity in cultures so that it supports flexibility, promotes diverse ideas and uses a variety of competencies in an

interprofessional care team. However, a few participants state that differences in culture may create conflict at work and may have a negative impact.

6.7 Communication and Interaction in Interprofessional Working

Another important theme arising from the interviews was interprofessional communication and interaction between health care professionals. Participants mentioned that they used different means of communication to communicate with service users and other professionals while they deliver health services. It is apparent from the interviews that most of the time health care professionals used verbal means of communication. Participants mentioned face-to-face meetings or discussion, telephone conversations, continuous medical education (CME) and clinical conferences are widely used to communicate with other colleagues at work. Participants gave a number of examples from all hospitals and professional groups. One medical professional from the public hospital states that they conduct medical conferences every morning to communicate between all professional groups in the hospital. He further comments that some of the health care professionals are competent and skilled for interprofessional communication despite of lack of written protocols and training:

> *There is a morning conference. That is one of the most important ways of communication. And, we communicate about a patient's health both formally and informally, verbally and by phone. Some of the professionals are competent and skilled but some of them are not. The relatively younger generation are more competent. There is no formal written protocol for interprofessional working. (A7-M)*

Another medical professional from the voluntary hospital states that the main means of communication between health care professionals is face-to-face. He highlights the problem related to documentation:

> *The main means of communication here is man-to-man (face to face) and telephones are also used. But mainly, there is a lack of proper documentation. (C4-M)*

One nursing professional from the private hospital experienced that the verbal means of communication is mostly used:

> *There are various means used for communication between the team members. For example, proper job descriptions and tasks are studied and then jobs are assigned to the individuals. Mostly, verbal communication is carried out. There are no proper policies and protocols involved. (C11-N)*

All medical professionals from all hospitals stated that they used medical notes to note their clinical assessment, management, findings, observations and treatment plan apart from fact-to-face meetings and verbal communication. One medical professional from the public hospital states:

> *There is no written protocol in the hospital. However we have a mechanism where the doctors write on the form or medical notes. That is a means of communication and sometimes we also communicate verbally. I have not found anything happening due to lack of communication, so I think all the members communicate effectively, although we have no training for it. (A2-M)*

Similarly, all nursing and all allied health professionals mentioned they use various forms and documents for recording assessments and test results. Few participants (4 nursing, 4 medical and 2 allied health professionals) mentioned that they used written memos as a

means of communication. However, it was clear from further enqueries that those memos were not used for communication for interprofessional working. They were used as a means of internal communication between various departments and groups for administrative and managerial purposes.

Few participants (3 nursing and 4 medical professionals) felt that many principles and objectives of departmental and team meetings were equally applicable to interprofessional care scenarios. According to them, team meetings were also held to decide the future courses of action, to understand each other's views and to come to consensual decisions on a certain agenda. They believed that team meetings or departmental meetings held for the discussion of interprofessional care issues, could improve interprofessional working relationships and could facilitate the sound decision making process.

Some participants (4 nursing, 8 medical and 3 allied health professionals) stated that they had direct access to senior clinicians and management teams and this makes their communication easy, open and honest. One nurse from the public hospital states:

> *We have vertical communication mechanisms, for example if we have a problem, we have to inform our seniors, and sometimes we have to go to management. We know the Head of Department of every department and we go directly to them if we have issues. Sometimes the team members communicate competently but not always because they do not always share things with each other. We communicate through telephone, face-to-face meetings, and verbally. (A4-N)*

Another nurse from the private hospital states that she uses verbal means of communication and she highlights the lack of written protocols for communication:

If I have to communicate with my fellow team members then I can communicate with them directly (verbally). There are no written protocols for the communication mechanism. I, as well as my team members, communicate effectively enough for us to carry out our activities. (B8-N)

One doctor from the private hospital points out the lack of mechanism for formal communication between health care teams:

There is no team-to-team formal communication mechanism. There are no written protocols or policies regarding interprofessional working. But informal communication happens all the time and I try to know as much as I can from the staff. That includes the reason for some complications arising in the patient, why problems have been found in patient care, why visitors have not settled, why the consultant has not been informed on time, why referrals and investigations haven't been completed on time. These are done in the form of verbal communication. As far as ICU is concerned, all staff members are competent and capable but when talking about the general ward, due to the high turnover of staff, we can't say whether someone is competent or not. (B9-M)

However, few participants (2 nursing, 1 medical and 2 allied health professionals) from the voluntary hospital stated that they had protocols or guidance for communication. They also highlighted the problem related to implementation of the policy. One medical professional from the voluntary hospital states:

There are policies for interprofessional team communication. There is a lack of proper documentation and implementation of the policy. (C4-M)

The standard of protocols and use of those protocols for effective communication is questioned by one allied health professional in the private hospital.

It is not that there is no mechanism of communication but that it is not very good. There are written protocols for communication mechanism. I don't think my team members communicate with me effectively. But also, here in this organisation the team members are competent. The main means of communication is verbal. (C5-A)

Some participants (5 nursing, 4 medical and 1 allied health professional) stated that they need to communicate with stakeholders and other health care professionals and effective communication helps to develop great working relationships with other professionals and service users. Health care professionals in Nepalese hospitals expressed their concerns for the lack of training, protocols and guidance for effective communication and interaction between health care professionals. One doctor highlights:

Even though, we (doctors, nurses and allied health professionals) work side by side daily and we communicate on a regular basis for many reasons, there is a problem with effective communication and interaction as different professionals have their own background, aims and roles. (B2-M)

One nurse mentions the lack of time as a barrier for effective communication and interaction between health care professionals.

We all work in a very busy environment and have barely time to focus on improving interactions and communication practices. (A10-N)

One allied health professional highlights the lack of organisational policy as a barrier for effective communication between health care professionals:

I am not aware of any organisational policies in this hospital that focus on improving communication, interaction and relationships between health care professionals. I do not think it is given importance by the organisation and staff

have not highlighted this issue to the management. Therefore, we health care professionals practise without organisational policies on interprofessional communication. (B7-A)

Some participants (4 nursing, 4 medical and 2 allied health professionals) pointed out that health care professionals used various technical terms, jargons and acronyms when they communicate with their clinical colleagues and service users on some occasions. One medical professional from the public hospital states:

Sharing of clinical information and the use of technical jargon is very common in the clinical set up. When we work together, we develop common understanding and use a sub-set of clinical terms and jargons that may be very unique to a specific group of clinicians. (A13-M)

The problem of using technical terms and jargon is faced by all groups of professionals in all hospitals. For instance, the use of acronyms is considered as a barrier for effective communication by a nurse in the public hospital.

Many clinicians use acronyms on the medical notes. For instance, when doctors prescribe medications, they write 'BD' on the medical notes to denote 'twice a day'. It is not always easy to understand these acronyms and their handwriting is not legible. It makes communication very difficult and sometimes it compromises patient safety. (A1-N)

Another nurse from the private hospital agrees and highlights the problem of using technical and medical terms.

Health care professionals go through rigorous training and education for learning and understanding common terminology and vocabulary. Words used in a common term, could be used in a different context and could be interpreted in a

different way in a clinical term. Therefore, communication is a very important and challenging aspect of interprofessional working. (B3-N)

According to some participants (6 nursing, 5 medical and 3 allied health professionals), one of the major reasons of conflict between health care professionals is poor communication. This can be seen in the following statement from a nurse from the public hospital:

We get recommended on occasions to communicate verbally and we do but the doctors say they haven't said so. Sometimes the juniors do not obey the seniors and that may cause conflict. (A4-N)

Another nurse experiences similar problems relating to misunderstanding due to communication and comments:

Sometimes doctors do not write details of medication to be used for patients and they do not clearly instruct us what to do and when to administer drugs to patients. Therefore, we use our knowledge in the best interest of patients in cases of emergency. Then doctors seem unhappy with us and misunderstanding occurs. (C1-N))

A nurse from the private hospital points out one of the root causes of conflicts is due to poor verbal communication between health care professionals:

Conflicts arise more often than we think. Mostly, conflicts arise when we are conducting rounds with the doctor. Whatever the doctor says during the rounds, we try to write it down. We make notes on the "Round book". But sometimes, some things might be missed. And due to this, conflict arises. (B12-N)

In summary, participants from all hospitals and professional groups stated that health care professionals used mainly verbal means (face-to-face, phone, case conference and

meetings) to communicate between health care professionals. Other means of communication mentioned by the participants were medical notes and forms. Participants highlighted that there were no written protocols and no proper mechanism of communication and interaction between health care professionals in public and private hospitals; whereas few participants from voluntary hospitals stated that there was written guidance for communication. Some participants felt that some of their team members were competent at effective communication. Participants stated various barriers to effective communication, such as lack of training, no protocols, use of technical jargon and insufficient time.

6.8 Involvement of Service Users for Clinical Decision Making

Involvement of service users in interprofessional working and clinical decision making was another important theme that came out of the interviews. Interprofessional care is delivered to service users and one of the objectives of interprofessional working practice is to deliver effective and improved health services to service users. Empirical research has demonstrated that more positive health care outcomes are achieved by engaging service users in clinical decision making (Colyer, 2012; CIHC; 2010; WHO, 2010; Pecukonis, et al, 2008).

Participants highlighted that interprofessional working in health care is achieved by understanding the shared and separate contributions provided by each member of the health care professional team to develop a focused plan of care for service users. Service users, carers and their families are important team members, who play crucial roles in decision making, care planning and management (Reel and Hutchings, 2007). Service user involvement for the effective delivery of health services is increasingly accepted by health service planners and service providers (Kaini, 2013). All participants from all hospitals pointed out that service users' awareness of their problems and understanding

from their perspectives are equally important to both sides – health care professionals and service users for the successful delivery of interprofessional care. One nurse from the private hospital states:

> *Whenever you are going to conduct a procedure relating to the patient, the patient should have a good idea of what is happening around him/her and should give consent on whether it should be carried out or not. (B1-N)*

The importance of understanding the service user is highlighted by an allied health professional from the voluntary hospital:

> *The most important thing is the understanding of the patient. (C8-A)*

Three nursing professionals felt that treating a patient with dignity and respect is important in the involvement of service users. One medical professional from the private hospital agrees and highlights:

> *In the context of Nepal, the health professionals should not try to cure the disease; they should try to cure the patient as a human being. (B5-M)*

Participants (10 nursing, 9 medical and 2 allied health professionals) expressed that involvement of service users for their care planning and management is valued by service users. One doctor states:

> *When I speak to patients and explain the problems, issues, pros and cons of the treatment; they always feel great. They feel that they are valued. (A13-M)*

One allied health professional from the voluntary hospital experienced that service users always feel great when they are fully informed of the issues, diagnosis and treatment. He comments:

Patients usually do not have the same amount of understanding that we or other health care professionals have. Therefore, they cannot fully participate in the decision making process. It is our responsibility to give them full information of their diagnosis and treatment. I have seen how patients are thankful to us for giving them detaiedl information. It is also a matter of satisfaction for us. (C5-A)

Christensen and Larsen (1993) also reports that interprofessional collaboration between various health care professionals enhance each other's skills and knowledge, which leads to continuous improvement on decision making for service users. Few participants (3 nursing, 2 medical and 2 allied health professionals) stated that the three different groups of professionals have different types of responsibilities and accountabilities in terms of making contact with service users and making clinical decisions. Nursing professionals stated that they spent most of their time with the service users as they work on wards for service users. However, nursing professionals mentioned that they cannot make decisions on their own without the input or clinical advice from medical professionals. In this context, it seems reasonable that nurses from all hospitals perceive that service users are sometimes involved in the decision making process. One nursing professional comments that there was limited involvement of service users in clinical decision making.

Doctor visits happen on a daily basis and patients are involved in some cases. (A1-N)

However, another nurse from the private hospital states:

The patient is directly involved in the decision making process. Everything is told to the patient and the patient has the rights whether to perform the procedure or not. I don't have any influence on the decision making process. (B3-N)

Participants from the voluntary hospital commented that medical professionals sometimes involved service users in the clinical decision making process. One nurse states:

> *Some of the doctors make the patient involved in the decision making process. (C1-N)*

One allied health professional comments that medical professionals involve service users in decision making. He states:

> *Doctors discuss with patients and ask their opinion before they make clinical decisions and they take note of the patient's opinion. (A6-A)*

It is evident from the interviews that nursing and allied health professionals perceived that medical professionals involved service users in making clinical decisions. Medical professionals have the legal authority and responsibility to make decisions for their service users (NMC, 2010). Medical professionals from all hospitals stated that they involved service users in the decision making process. One medical professional from the private hospital agrees and states:

> *We involve the patient most and if the patient is very sick we involve the patient's party in the decision making. (A7-M)*

One medical professional from the public hospital states:

> *We make decisions by case or patient assessment. During the assessment, we get information from patients, discuss their clinical issues and give them the information they need. That's how we involve patients in decision making. Sometimes in case of emergency patients may not be involved. We give options to patients and let them choose and work as their wish. (A11-M)*

Another medical professional from the private hospital states that he involves service users in the clinical decision making process:

As a doctor, I give the best options to the patients and let them decide what is best for them. The patients are always involved in the decision making process. (B2-M)

Another medical professional from the voluntary hospital shares a similar experience:

.... as much as possible we involve the patients. But in case of emergency, we conduct the procedures first and tell the patient afterwards. (C3-M)

Two medical professionals stated that health care professionals discuss a number of patients at a time at interprofessional team meetings. According to them, this was one of the reasons that it was not possible to involve service users during the discussion of cases. However, this does not prevent health care professionals having discussions with service users for their diagnosis, treatments or referrals.

The three hospitals do not have an organisational policy for the involvement of service users on clinical decision making. There were no written consent policies in any of these hospitals under study. It is noted that all hospitals use a consent form before service users go for any surgical interventions or procedures. It was noted that there is no mechanism to audit, monitor or evaluate the effectiveness of implementation of consent forms. The involvement and engagement of service users in the delivery of health services and clinical care should be reflected in organisational policies. In addition, health care organisations should show commitment to developing guidelines for health care professionals working in interprofessional care teams. It can be a part of the job description of health care professionals. To translate written guidance into practices, health care organisations need to provide information, training, education and infrastructures to health care professionals so service users can effectively engage and participate in the clinical decision making process.

To summarise, participants perceived that service users valued their involvement in clinical decision making. Medical professionals perceived that they involved service users for clinical decision making and took ownership of those clinical decisions. Nursing professionals felt that they sometimes involved service users in clinical decision making, but felt that medical professionals mostly involved service users in making clinical decisions. Allied health professionals had the same perception, but they stated that they did not involve service users for clinical decision making.

6.9 Perceived Benefits of Interprofessional Working

Participants describe various benefits of interprofessional working to service users, health care professionals, health care systems and health care organisations. Thirty-four participants (90% of the total participants; 13 nursing, 11 medical and 10 allied health professionals from 11 public, 13 private and 10 voluntary hospitals) described the benefits of interprofessional working to service users:

> *If you look at the total outcome of the patient, one person on our team most of the time may not deliver the full treatment to the patient. A patient has a problem many times but starts with another symptom. (A2-M)*
>
> *While working alone, one might not recognise their own weaknesses. If he is in the team then his weakness can be pointed out by others and vice versa. This creates effectiveness in the interprofessional care team as no one is perfect and an effective team leader can deliver effective health services to patients. (B2-M)*
>
> *Interprofessional working is the most important factor while working in the hospital. You can do nothing at all just by yourself. Doctors, nurses and other supporting staffs make a team capable of working for the welfare of the patient. Every profession's support is required. (B8-N)*

Interprofessional working is very important. Without teamwork, patients cannot receive authentic treatment. Due to interprofessional care, the patient can receive an authentic/exact service which is required for him. Starting from the diagnostics, the patient can receive quality service. For us, working in the interprofessional team can bring advantage to the institute. The reputation of the hospital can increase due to this. To improve interprofessional working, the team members should be co-operative with each other and should be ready to work in a team. (C5-A)

I feel down when other professionals do not show a positive attitude towards interprofessional collaborative practices. If someone does not have that sort of attitude, it is discouraging and de-motivating. It gives me a sense of isolation, rather than collaboration. Obviously collaboration is always helpful to patients. (A12-A)

Others described the benefits of interprofessional working to different stakeholders.

Due to interprofessional working, patients get an accurate service and health care professionals get better exposure. The organisation gains goodwill. But, it has to be properly supported by leadership, supervision, guidance, training, education etc. (C1-N)

There are many benefits of being in an interprofessional team. The common thing is that there is a harmonious relationship among the staff. At the same time, we can learn from others and share our weakness with others. Organisations, of course would benefit through team collaboration. (A6-A)

Interprofessional working helps proper information to flow between professionals. Therefore, it helps to improve quality of health care received by the

patients. If the health care gets better due to all of the above reasons, then the patient flow in the hospital increases and the organisation directly benefits. Mainly, the institution should support proper interprofessional working. (B9-M)

Participants perceived that service users, health care professionals and health care organisations benefit from interprofessional working; ineffective collaboration between health care professionals has many disadvantages. One allied health professional from the private hospital states the consequences of poor interprofessional working:

Without interprofessional working, an organisation does not work by itself. If there is no proper network between all the parts of a hospital i.e. the doctors, nurses and the paramedics then the whole system collapses. (B7-A)

One nurse interviewed states that the benefit of interprofessional working is not discussed at the team meetings as it should be:

We discuss patient issues and cases at the morning conferences and we practice interprofessional working on a daily basis. It happens spontaneously without plan or without talking about 'interprofessional working'. We hardly discuss the benefits of interprofessional working in any forums or meetings. (A8-N)

All participants felt strongly that working in an interprofessional care team helped to enhance their knowledge and competency, which was considered as one of the factors for improving employee satisfaction in health care organisations. Nurses believed that they learnt skills and competencies for interprofessional working while working with doctors. Similarly, allied health professionals stated that they felt happy working with other colleagues in an interprofessional care team. Participants believed that interprofessional working was beneficial to them, service users and health care organisations; and they believed that interprofessional working helped to improve quality of care, staff

satisfaction, better team performance, better communication and interaction. It can be concluded from the interviews that health care professionals from all groups and hospitals clearly perceive various benefits of interprofessional working to all stakeholders including service users, health care professionals, health care systems and organisations.

6.10 Perceived Barriers and Challenges of Interprofessional Working

As mentioned in the section above, participants described various advantages and perceived benefits of interprofessional working to service users, health care professionals, health care organisations and systems. Many research scholars and authors have confirmed the benefits of interprofessional working to various stakeholders. However, all participants from all hospitals in this research pointed out obstacles, barriers and challenges of interprofessional working. These barriers and challenges are related to personal, professional and organisational factors depending on the nature of interprofessional working. In terms of organisational barriers, most of the participants stated lack of training and education, lack of local policies and national strategies for interprofessional working.

Medical professionals from the three hospitals point out various barriers and challenges of interprofessional working:

> *We do not understand each others' roles and responsibilities in terms of working together and it can be an obstacle. It is really important to define our roles clearly when we work in a team. Egoism is another obstacle for interprofessional team working and it should be stopped. (A11-M)*
>
> *Not understanding the feelings of others is a major problem or barrier for interprofessional working. Communication barriers exist here as there is a feeling that lower professions, such as nursing or allied health professionals; should*

always be suppressed. I think that the nurses feel suppressed more than any other professions. There is no understanding that there is a difference in culture between the professions. Medical dominance is also a barrier. (B2-M)

The major barriers can be more workload and lack of proper time for interprofessional working. We can't think about what the other professions are thinking and this can act as a barrier to interprofessional working. Lack of proper communication is also a barrier between the professionals in a team. (C3-M)

Nurses also state that there are many barriers and challenges to interprofessional working in hospitals:

If there is no mutual respect between the professions, problems arise. Another barrier we find is the communication barrier i.e. low level of communication. Communication problems definitely exist between the individuals, but it totally depends on a personal level. Lack of discipline, lack of proper training etc. also act as a barrier to interprofessional working. Medical dominance is also a barrier for interprofessional working. (B3-N)

Not underestimating other professions is a barrier for interprofessional working. Lack of education and training are also problems here in this hospital. (C2-N)

Similarly, allied health professionals from all hospitals highlight similar barriers and challenges of interprofessional working:

I think professional isolation and silos are the barriers to interprofessional working. Moreover, lack of training for health care professionals to enhance their skills and knowledge plays a negative role for interprofessional working. Separate professional culture in each profession is another challenge for interprofessional working. (A3-A)

First of all, there is no interaction between various professions except sometimes on the phone. We (allied health professionals) are completely isolated. There is no training on interprofessional working as the hospital management isn't interested at all. In the lab itself, differences in cultural background can act as a barrier. (B6-A)

Negative attitudes, knowledge, education, lack of communication, lack of training, medical dominance can be mentioned as some of the barriers in the interprofessional care team. (C5-A)

Negative attitudes and personal egos are barriers to interprofessional working. Lack of education and training are also barriers to interprofessional working. Lack of understanding between the different types of professionals is also a major barrier here in this hospital. Communication gaps, personal relationships can also act as gaps and barriers for interprofessional working. (C7-A)

One medical professional states the lack of understanding of the scope of interprofessional working as a barrier:

One of the most important factors that hinder the interprofessional working in this country is lack of understanding of the scope of interprofessional collaborative practice and very limited awareness of interprofessional working among health care professionals. (A7-M)

One allied health professional highlights similar issue and states:

We have team meetings. We mostly discuss management and technical issues at the team meetings. We (allied health professionals) are not included in the clinical meetings. I have not come across any meetings that discuss the benefits of interprofessional care. Due to lack of understanding and lack of a proper forum

to discuss interprofessional working, we are lagging behind in many areas of interprofessional collaborative practices. (C7-A)

All participants from all hospitals stated that they face conflict at work at some point of time when working with other health care professionals. Conflict in care and tensions between health care professionals due to poor communication, understanding, personality styles or egos and overlapping roles were repetitive themes that came out of the interviews.

Allied health and nursing professionals think egos of medical professionals is a source of conflicts.

Doctors' personality and their ego of 'being a doctor' sometimes creates conflicts between us (health care professionals). I mean it is a barrier for personal and professional relationships between us and we hesitate to express our concerns due to this. (B10-N)

Webster (2002) asserts when interests and roles of health care professionals clash with each other, this may be a source of conflict and it may maintain the demarcation of professional boundaries and finally hamper effective communication within the health care team. One allied health professional comments:

When I am doing physio, one nurse in charge told me that I did not do enough physio with the patient. I responded by saying that it is my job to do physio and I know how much I should do. In this way I had a conflict. (A5-A)

Heavy workload, conflicting and demanding priorities were some issues participants raise and mention them as a source of conflict. One medical professional highlights:

There can be many examples of conflicts. For example, when we are working in the emergency ward, we are in bit of a rush and have to clear the patients' beds as

quickly as possible. This creates misunderstanding between the doctors and the nurses and this result in the conflicts. (C3-M)

A nurse from the voluntary hospital adds:

Some minor conflicts arise within these professions. When there is an overload of work in the operating theatre and we have to import staff from outpatient departments, then, during the assessment by the professionals, sometimes minor conflicts arise. (C11-N)

Health care professionals thought conflict is a part of their professional life and may not necessarily affect the delivery of health services. One medical professional from the public hospital states:

Conflict is natural, it happens but it does not affect the patient's care as we seek the best way of improving patient's health. But it affects social and development factors. (A11-M)

Participants expressed that they experienced cultural and professional barriers whilst working in an interprofessional care team. One nursing professional from the private hospital comments:

Different colleagues (health care professionals) have different perspectives. Their motivation, perspectives of the care and communication styles are different and it depends on how you were brought up in the professional career over a long period of time. Some health care professionals overcome these barriers by working together and learning from each other. (B8-N)

Participants pointed out how dual roles can be a barrier and it can be a problem to an interprofessional care team. One medical professional from the private hospital states:

> *Interprofessional working relationships can be miserable when health care professionals have a dual role or no clarity of roles. This situation creates conflict and may be a barrier to interprofessional working between health care professionals. (B5-M)*

According to Engel and Gursky (2003), health care professionals need to defeat those barriers in order to promote shared goals in which all professionals can work together and can make a positive contribution to achieve common objectives and desired optimal outcome.

From the interviews, it is apparent that participants highlighted barriers related to personal and interpersonal skills or issues such as ego, negative attitude, no respect to others, poor communication skills. Nursing and allied health professionals specially pointed out dominance of medical professionals as one of the major problems they were facing in terms of interprofessional working. In summary, participants highlighted the following challenges and barriers to interprofessional working.

- Lack of education and training
- Poor interpersonal skills
- Poor communication skills
- Dominance of medical professionals
- Ego, negative attitude, no respect to others
- No organisational protocols or guidance
- High workload
- No support from management

It can be concluded that participants experienced conflicts while working in an interprofessional care team. Participants stated that some of the barriers or challenges

stated above may create conflicts and tensions between and among health care professionals. Most of the participants commented that conflicts had a negative impact on service delivery and interprofessional working.

6.11 Summary

This chapter has outlined various themes and subthemes arising from interviews with health care professionals and analysis of hospital documents such as hospital guidance, protocols, strategies, organisational structures and job descriptions. The study suggests that health care professionals experienced interprofessional working in health care as beneficial to all stakeholders and they perceived that it is one of the best approaches for effective delivery of health care by working together.

The study concludes that medical professionals dominate overall health service delivery; they lead interprofessional care teams, they make decisions and they are the most influential group in Nepalese hospitals. However, nursing and allied health professionals thought that this is gradually changing and their roles and contribution in health service delivery is being recognised in Nepalese hospitals. Nursing and allied health professionals felt limited involvement in clinical decision making and they shared mixed responses regarding professional autonomy, identity and boundaries.

Participants highlighted that Nepalese hospitals and educational institutions did not run formal and informal training for interprofessional practices; and they did not have organisational guidance, policies and protocols for interprofessional working despite the fact that hospital team leaders were found to be supportive and competent of leading their teams. Participants stated that different professionals have different values, beliefs, skills, norms and cultures due to differences in education, training and background. Many participants stated that difference in professional culture between health care

professionals is good for interprofessional working; whereas few participants thought it was not good for interprofessional practice.

Most of the time health care professionals used verbal means of communication. Health care professionals used medical notes, other forms and documents to record clinical consultation, findings, outcomes, decisions and results. Participants thought that poor communication created conflict and tension between health care professionals. Involving and engaging service users for clinical decision making were thought to be one of the best ways of improving interprofessional practices. Participants have mixed responses regarding involving service users for clinical decision making and delivery of patient care.

Participants highlighted various perceived benefits of interprofessional working such as improved quality of care, improved staff satisfaction and team performance through a holistic approach to care, better communication and interaction. They have also pointed out various barriers and challenges of interprofessional working in Nepalese hospitals such as lack of education, training protocols, guidance; poor interpersonal and communication skills; dominance of medical professionals; ego, negative attitude, no respect to others; and no support from hospital management and board.

Recognising the problems, participants suggested that there are ways for improving interprofessional working. Participants suggested that provision of training and education to all groups of health care professionals, development and implementation of policies and protocols for interprofessional working, organisational support for promoting culture of interprofessional working, strong clinical leadership, promotion of culture of mutual trust and respect, open and effective communication as ways of improving interprofessional working between health care professionals.

Chapter 7: Discussion

7.1 Introduction

The previous Chapter presents the findings with categories and themes that arose from the data from the semi-structured interviews with the three groups of health care professionals and documentary analysis of procedural documents. This chapter discusses the perceptions of interprofessional working among health care professionals and critically examines the power theory in the context of literature on interprofessional working and the theory of professions. This chapter considers, explores and discusses the descriptive and reflexive accounts of participants, organisational requirements and settings, power relationships between health care professionals and the interactions with the subject to examine how health care professionals collaborate and to assess their perceptions of interprofessional working on health care delivery in Nepalese hospitals.

This chapter discusses the findings of the study and relates them to previous literature and to the objectives of the study. The main aim of the study is to examine how health care professionals collaborate and to assess their perceptions of interprofessional working among health care professionals on health care delivery. This study has four main key objectives. These objectives are:

- To identify and analyse factors perceived by health care professionals that support and hinder interprofessional working in Nepalese hospitals
- To examine the understanding and perceptions of interprofessional working among health care professionals in Nepalese hospitals
- To assess perceptions of interprofessional working on health care delivery in Nepal

- To examine professional power perspectives of the theory of professions in relation to interprofessional working

This chapter is mainly divided into three sections – perceptions of health care professionals on interprofessional working, power perspectives of the theory of professions and clinical governance in the context of interprofessional working. These sections are categorised on the basis of the main themes from the findings, which are linked with research objectives and research questions. This chapter explains how the results achieve the research objectives and how the findings fit in with existing knowledge on this topic.

7.2 Perceptions of Interprofessional Working among Health Care Professionals

Perceptions of interprofessional working among health care professionals based on their experiences are explored in this section. The findings of this study established health care professionals from all hospitals under study and professional groups perceived interprofessional practices positively. The study covered a total of 38 health care professionals in this research from three different hospitals. In the research the participation of nurses was 40%, medical professionals was 34% and 26% were from allied health professionals. Furthermore, almost equal number of participants belonged to each type of hospital – public, private and voluntary hospitals of Nepal. They were also aware of the importance of interprofessional working for the effective delivery of health services even though interprofessional working is relatively a new concept in the context of Nepalese health care. Interprofessional working ensures health care professionals working together for the benefit of all stakeholders and to deliver health services that they could not offer effectively on their own. It has been seen as a way of improving the outcome of health services. D'Amour and Oandasan (2005) confirm that interprofessional

working creates a positive impact on patient, professional, organisational and system outcomes. Way et al (2000) carried out a research on physician and nurse practitioners' collaborative practices and argued that collaborative practices influenced the way primary health care organisations are run and managed. There is very little doubt about the perceived benefits of interprofessional working to various stakeholders and this study has proved it in the context of all health care professionals and all Nepalese hospitals under study.

This study confirms that health care professionals from all hospitals under study and professional groups perceived consensual decision making was good for service users, even though all health care professionals did not have equal involvement in clinical decision making. It is important to involve all health care professionals and service users in order to decide care plans and management as different health care professionals have different perspectives, skills and experience to meet service users' clinical needs and based on research evidence. Health care professionals' behaviours, knowledge and skills can have an effect on how service users and other health care professionals feel involved and supported (Hibbard et al, 2010). Research on shared decision making in the UK confirm that shared decision making enhances service users' '*knowledge about their condition and treatment options, satisfaction, self-confidence and health care professionals' communication with service users*' (Silva, 2012, p.iv).

One of the features of interprofessional working is consensual clinical decision making (Carnwell and Buchanan, 2005). Moreover, Natale et al (1998) highlight the importance of decision making skills for health care professionals. Health care professionals usually involve in formal clinical decision making processes. Health care professionals use their authority, power and expertise in the formal decision making process (e.g. referral, care plan, treatment) in terms of interprofessional care. They are also involved in informal

decision making process (e.g. informal consultation or discussion) through networking. However, it is not easy to assess their intensity of involvement at the formal and informal decision making process. Various factors such as knowledge, skills, roles and organisational policies influence the clinical decision making process.

It is interesting to note that a majority of the health care professionals from these hospitals and all three professional groups experienced overlapping roles between health care professionals despite stating that their roles and responsibilities are defined. The delivery of health care involves complex decision making and interprofessional care and is not a formal structure. Therefore, it is difficult to fix definitive roles for health care professionals in an interprofessional care environment. Another reason for overlapped roles may be due to the involvement of various health care professionals for the same ailment. Moreover, health care professionals play different roles in order to deliver health services to service users. Apart from the clinical roles, some senior health care professionals experienced that they had to play other managerial roles such as roles of a facilitator, team leader and co-ordinator. This is consistent with literature on interprofessional working in health care. Hornby and Atkins (2000) argue that health care professionals' have to play different roles; and roles and responsibilities may overlap. Overlapping and blurred boundaries are mentioned as barriers of interprofessional working by Barrett and Keeping (2005) and Loxley (1997). It is also noted from the interviews that many health care professionals play extended roles and support various professionals and multi-disciplinary teams in health services. Overlapping roles and cross-professional working practices may overshadow defined roles of health care professionals (Booth and Hewison, 2002).

This study confirms that if service users are engaged in their care plans and treatment decisions, health care professionals from all hospitals under study and professional

groups perceived that it helped them to create a complete picture of service users by evaluating all their perspectives. The literature suggests that involving service users, patients and public in their own health care and in the planning, review and delivery of health care has become a key element of health care policy in recent years. The role of service users in interprofessional care teams is clearly highlighted by authors and organisations (Department of Health, 2004; Colyer, 2012). Moreover, Suh and Lee (2010) conducted research on impact of shared decision making on patient satisfaction and confirmed that it improves service users' satisfaction with care.

Interprofessional care, by its nature, includes various health care professionals from different backgrounds and cultures. This study confirms that health care professionals from all hospitals under study and professional groups perceived different health care professionals have different professional cultures, values, beliefs and norms due to their education, training, different backgrounds and roles. Culture is defined as '*shared values, beliefs and practices, ... culture thus defined operates various health, social or economic problems*' (Browne et al, 2009, p.168). Hall (2005) asserts that each health care profession has a different culture which includes values, beliefs, attitudes, customs and behaviours. Each health profession possesses its own professional culture that determines core values, custom, the meaning, attribution, and aetiology of symptoms, as well as what constitutes health, wellness and treatment success (Pecukonis et al, 2008). Professional culture cannot be separated from academic activities, social norms and experiences. Health care professionals stated they would be more loyal to their professions than other professions and this may be another reason for having different norms, values and beliefs of different health care professionals. O'Daniel and Rosenstein (2008) assert that '*issues around gender differences in communication styles, values and expectations are common in all workplace situations*' (p.4). Their research on interprofessional collaboration in

hospitals across the United States has identified gender, culture, ethnicity, differences in language, hierarchies, personality and generational differences as barriers to interprofessional collaboration and communication between health care professionals.

This study confirms that there is no training and education on interprofessional working at work and at universities and colleges in Nepal. This is a common view of all health care professionals from all hospitals under study and professional groups. This might have a great impact on their learning and development for interprofessional working. One of the interesting findings in this study is that health care professionals learnt skills and competencies at work through the 'learning by doing' approach; hence they felt more competent and skilled at work to deliver interprofessional care. This study highlights the importance of interprofessional learning at work and suggests that the 'learning by doing' approach could be one of the best approaches in interprofessional learning and working. Hojat et al (2001) confirm that learning from each other in interprofessional care helps to gain knowledge and skills. The literature suggests that interprofessional education, learning and working are closely related and interprofessional working cannot be thought, implemented and sustained without interprofessional learning and education. According to Barr (2005), interprofessional education and learning can directly contribute to improving interprofessional working and collaboration in practice. Borrill et al (2000) argue that interprofessional learning can improve mutual respect and understanding between health care professionals, and can contribute to deliver effective health care to service users.

Health care professionals work together and learn from each other. Therefore, this can be seen as a socialisation process they learn throughout their career and it may have an impact on their behaviours, values and beliefs. It was observed that some of the learning were due to the interprofessional nature of their roles, in which they need to work with

other professionals and learn from each other. They also learn few other things in the socialisation process due to their personal interest, which is more self imposed in nature. Socialisation enables health care professionals to understand interprofessional working, different roles, skills and culture around them.

Evidence suggests effective communication and interaction between health care professionals and service users; and among health care professionals affects patient experience and clinical outcome, which is discussed in Chapter 2, Section 2.5. This study also highlights that health care professionals emphasised the importance of communication for interprofessional working and thought that it was a foundation for the development of interprofessional working in health care organisations. Interprofessional care and team related communications may help to exploit opportunities that influence team interactions, organisation and functioning (Essens et al, 2009). The main objective of effective communication is to bring clarity and simplicity between health care professionals and service users and to deliver successful interprofessional care. Therefore, an interprofessional care team must be sure about the background and ability of team members and ways for effective communication and interaction. Effectiveness of an interprofessional team relies on the ability of team members to communicate with each other (Tanco et al, 2011). This may bring trust between health care professionals and may improve the quality of care. Interprofessional and interpersonal communication is an essential feature for the development of interprofessional working in health care team (Evans, 1994; Fagin, 1992; Henneman et al, 1995; Mariano, 1989).

This study confirms that health care professionals believed open, honest and effective communication between health care professionals is required for interprofessional care and it enabled them to communicate their own ideas and thoughts, listen to the views of others and negotiate care plans and management. Few participants (5 nursing and 3 allied

health professionals) felt they usually did not challenge the views of medical professionals and thought it may hamper interprofessional care. It may be due to the social background and gender of nursing and allied health professionals. Also, this practice can be viewed as inappropriate for practising interprofessional care in a fruitful manner. Nursing and allied health professionals are mainly from a working class background and nursing is a female only profession. Fagin (1992) and Norman (1983) assert that unequal social status among health care professionals and gender stereotypes are barriers for interprofessional working. One nursing professional commented that medical professionals feel 'professional supremacy' due to the recognition they get from the public and other professionals.

One nursing professional commented that the nursing profession is still considered as an auxiliary profession to medicine. Another nurse stated that nurses are dependent on medical professionals and maintain sub-ordinate relationship with them. Therefore, understanding medical authority, supremacy and medical knowledge and behaving or working accordingly to maintain better relationships between all professional groups is helpful for successful interprofessional working. Whereas a theory by Gabe et al (1994) suggests that due to the advancement in clinical knowledge, diagnostic and therapeutic technologies and recognition of sub-specialties in health care; medical professionals are becoming less homogenous. Hence, medical professionals are dependent on nursing and allied health professionals. Freidson (1986) states that the nursing profession is performed in a very elaborate and highly technical division of labour with nurses subordinate to some and themselves subordinate to their own supervisors. Miller et al (2001) describe that the nurses' role in interprofessional care has important 'historical and social antecedents'. Health care professionals highlighted the need of organisational support and support from team leaders to promote a culture of openness and

assertiveness. The codes of conduct of professional councils advises that it is a duty of health care professionals to speak up if they are not in agreement with other health care professionals.

An open communication approach encourages issues to be raised about service users, professional concerns and personal difficulties with service users and other colleagues. Verhorsek et al (2010) asserts that openness in communication promotes a strong and safe learning environment. It may create opportunities for offering input and feedback, and taking actions for the correct procedures. Barrett and Keeping (2005) suggest that open and honest communication is, however, dependent upon internal feelings linked to an individual level of knowledge, skill and confidence.

This research suggests that health care professionals use different forms, ways and means of communication; such as co-operation, consultation, discussion, face-to-face meetings and multiple entries on notes; during interprofessional working. A number of participants (4 nursing, 4 medical and 2 allied health professionals) mentioned that they used written memos as a means of communication. Additionally, few participants (3 nursing and 4 medical professionals) felt that many principles and objectives of departmental and team meetings were equally applicable to interprofessional care scenarios. On the other hand, some participants (4 nursing, 8 medical and 3 allied health professionals) stated that they had direct access to senior clinicians and management team and this makes their communication easily, openly and honestly. These forms of communication may occur in any situation, and in teams and hospitals. The Canadian Interprofessional Health Collaborative (2010) states that communication in an interprofessional care environment is demonstrated through listening and other non-verbal and verbal means through negotiating, consulting, interacting, discussing or debating. According to Bope and Jost

(1994), factors such as nature of the task, resources available, skills, geography, legal and financial constraints influence the form of interprofessional working.

This research confirms that team meetings in Nepalese hospitals were regularly held for various reasons; such as clinical decision making, information sharing and team management. It was observed that selected clinical cases are presented, discussed and decisions are made at these meetings and various health care professionals engaged in the decision making process. This is one of the ways of learning from each other and making valid clinical decisions. Formal or informal sessions, meetings and forums are integral parts of interprofessional working and health care organisations can benefit from these types of discussions and interactions for making interprofessional working successful. However, it is not easy to determine how effective communication and interaction contribute to improved quality of care due to lack of measurable clinical outcomes in Nepalese hospitals. Borril et al (2002) highlight the importance of group discussions and role play for interprofessional working. Delva et al (2008) found that information from team meetings was inconsistently shared or was incomplete and this hindered performance. They further highlighted that variations in operational approaches used by the different teams were also problematic.

This research concludes that health care professionals in all hospitals used medical records, charts and documents to note health care plans, management and delivery of patient care and as a means of communication between health care professionals. Bope and Jost (1994) assert that record keeping or medical records are the most important form of communication in health and social care. During the observation of hospital documentation, clinical care records were found in the individual health or medical records of the service users. However, the nature of the medical records and team records were varied on the nature, purpose and composition of the team and hospital. Moreover,

the common practice was that the hospitals handed over medical records to service users; they owned the records and they were responsible for safe keeping of records. Therefore, records were not always available at the hospital until service users visited the hospital with their records.

This research suggests that time constraint; different aims, roles and background, lack of organisational policies are barriers to effective communication and interaction between health care professionals. Many research scholars (Fitzsimmons and White, 1997; Lingard et al 2002; Mills et al, 2008; Street and Blackford, 2001; Verhovsek et al, 2010) have highlighted various factors such as personal styles, ego, historic tension, conflicting viewpoints, different backgrounds and working styles that can make communication between health care professionals challenging. Some participants (4 nursing, 4 medical and 2 allied health professionals) pointed out that health care professionals used various technical terms, jargon and acronyms when they communicate with their clinical colleagues and service users on some occasions. Interprofessional working and effective communication are essential for effective clinical practice and for communicating critical information accurately (O'Daniel and Rosenstein, 2008). According to The Joint Commission (2005), due to ineffective communication such as lack of critical information, misinterpretation of information, unclear orders over the telephone and overlooked changes in status, patient safety in hospitals is at risk.

Health care professionals perceived that they used technical terms and jargon due to the clinical and technical nature of work. This was considered as one of the challenges of interprofessional working and collaborative practices in Nepalese hospitals. To ensure effective communication between health care professionals and service users, language used between them has to be tuned and understood in a context. If this does not happen,

other professional groups may be excluded from the conversations and there could be poor communication or sometimes absence of communication (Colyer, 2012).

This study highlights the lack of engagement of health care professionals in the interprofessional care process and building strong interprofessional relationships due to various challenges and obstacles. The lack of engagement was a surprising finding as most of the participants stated that they were willing to work, communicate and interact with other professionals for successful interprofessional working. One factor to be considered is the voluntary nature of interprofessional work in Nepalese hospitals due to the lack of formal strategies, policies and guidance. The literature also suggests that interprofessional working is voluntary (D'Amour et al, 1999). However, Henneman et al (1995) assert that willingness to work with other professionals is built on various factors such as interprofessional education, learning and previous experience.

Health care professionals from all hospitals and professional groups perceived various factors that support interprofessional working such as training and education; organisational protocols and guidance for interprofessional working; strong leadership; support from organisations, flexible rules, competent and confident workforce, clear job description and supervision. These factors are already described in the previous literature. The literature suggests that interprofessional working is influenced by organisational factors, such as organisational culture, policies and regulations (Drinka and Clark, 2000, Payne, 2000 and Reel and Hutchings, 2007); protocols or guidance (D'Amour et al, 1999; Willumsen, 2006); training and education (ECIP, 2005; Mickan et al, 2010; WHO, 2010).

Organisational support, such as resources, education and rewards for interprofessional working are vital for the successful delivery of interprofessional care (Petri 2010; D'Amour et al 2005; Henenman, 1995). Mickan et al (2010) assert that a clear organisational policy and expectations, open, honest and regular communication; and

supervision are important for the development and implementation of interprofessional working and collaborative practice agenda in health care organisations. Martin-Rodriguez et al (2005) assert that organisational determinants such as managerial leadership and expertise, human resources, training and funding are identified as major factors to support the development and implementation of interprofessional working and collaborative practices in health care organisations.

Interprofessional working does not occur smoothly. Several barriers to interprofessional practices perceived by health care professionals from all hospitals within the structure of Nepalese hospitals and between health care professionals. The most commonly stated barriers are lack of education and training, poor interpersonal skills, poor communication skills, ego, negative attitude, a lack of trust and mutual respect, no policies and protocols for interprofessional working, high workload and no support from hospital management. These challenges and barriers to interprofessional working were already recognised in literature by various scholars and authors as discussed in Chapter 2. In light of these barriers, ways to improve interprofessional practices in Nepalese hospitals are discussed in detail in the next Chapter.

To conclude, this section discussed the perceptions of health care professionals of interprofessional working in health care delivery. It includes learning from each other, consensual decision making, overlapped roles, service users' involvement in interprofessional care, and cultural differences in an interprofessional care environment. This section also discusses the ways, means and different forms of interprofessional communication and interaction between health care professionals in Nepalese hospitals. This section highlighted the importance of communication between health care professionals, the use of informal communication and multiple entries on medical records for interprofessional care. Moreover, various obstacles and challenges to interprofessional

working, interaction and communication were discussed in this section. Finally, this section discussed perceived factors supporting interprofessional working and perceived barriers to interprofessional working in Nepalese hospitals. Organisational support, structure and practices balance professional independence with professional interdependence and help to improve interprofessional working practices in hospitals.

7.3 Professional Power and Interprofessional Working

The professional power approach of the theory of professions and its theoretical perspectives have been described and analysed critically in the previous Chapter 3. As described earlier, this study also examines professional power perspectives of the theory of professions and assesses how health care professionals perceive interprofessional working. Therefore, this section examines the findings of the research in relation to the power approach of the theory of professions in the context of Nepalese hospitals.

This study compares three health care professional groups with each other in terms of interprofessional working and collaborative practices. It is concluded that medicine is the most established and dominant profession amongst all professions in the context of Nepalese health care. Health care professionals believed that it is due to their roles, education, knowledge, expertise and hierarchical organisational structures; and the respect and recognition they receive from the public and other professionals in Nepal. The theory of professions (Freidson, 1970a, 1970b) suggests professions need specialised knowledge and extensive training and that profession is regulated, tends to be autonomous and the responsibilities lie with the individual professional.

Participants from fourteen nursing and 6 allied health professionals; (i.e. ninety-three percent nursing and sixty percent allied health professionals) belonging to all hospitals (7 from the public hospital, 6 from the private hospital and 7 from the voluntary hospital) suggest that dominance of medical professionals could be a source of conflict between

health care professionals and it is considered a barrier to interprofessional working. Irvine et al (2002) argue that conflicts over authority, power, control and jurisdiction create barriers to interprofessional working as health care professionals tend to defend their professional identity. Furthermore, existence of medical dominance in health care (Freidson, 1970) and top-down approaches to interprofessional relationship (Irvine et al, 2002) are seen as a source of tension for other non-medical health care professionals.

Another important issue raised by this research in terms of interprofessional working and relationships is hierarchy. Freidson (1970a) suggests that professional power of medical professionals comes from autonomy; and they become dominant and control other professions. The findings show maximum participants (13 nursing, 5 allied health professionals and 13 medical professionals from 11 public, 11 private and 9 voluntary hospitals) have agreed that medical professionals are on the top of the professional and organisational hierarchy in Nepalese hospitals due to their roles, education, experience, recognition, background and expertise. Medical professionals are not only involved in leading and managing clinical aspects, but also lead the overall business and operational aspects of hospitals management in Nepalese hospitals. Hence, the theory is in alignment with the results of the interviews conducted. Participants, especially nursing and allied health professionals blamed hierarchies in Nepalese hospitals for poor communication and ineffective interprofessional working. This finding is consistent with the literature. Researchers (O'Daniel and Rosenstein, 2008; Baxter and Brumfitt, 2008; Loxley, 1997) noted that hierarchies exist in health care and medical professionals are on the top of the hierarchy most of the time. Hierarchy is related to division of power (Johnson, 1972) and this is one of the barriers to interprofessional collaboration (O'Daniel and Rosenstein, 2008). According to The Interprofessional Education Collaborative (2011), hierarchies in health care organisations create professional differences and also create dysfunctional

relationships, which is one of the challenging aspects of interprofessional working. Delva et al (2008) highlighted that power differences were attributed to the hierarchical organisation of the hospital system with its policies lacking in relevance to the primary care setting and the traditional power held by doctors. Traditionally, there has been a power gap between doctors and nurses and it is a known fact that a well-documented professional hierarchy exists in health care (Henneman, 1995).

This study confirms that medical professionals make clinical decisions and take ownership of the decisions in Nepalese hospitals. It is positive that decision makers also take ownership. A positive observation derived from the interviews conducted revealed all participants felt interprofessional working should be sufficiently motivated and recognised amongst health care professionals with adequate appreciation from each other and from all stakeholders. Nursing and allied health professionals experienced no equal involvement of all health care professionals on clinical decision making. Equal involvement is not practical and not required for all cases. As per the results of the study, it was found that all health care professionals did not believe they had an even degree of influence on the decision making process. As per the observation, only some participants (5 nursing and 10 medical professionals) agreed they are actively involved in the decision making even though all participants stated that medical professionals make clinical decisions. Involvement of health care professionals in clinical decision making is directed by health, ailment and need of service users. Equality between participating health care professionals is one of the attributes of interprofessional working that gives a chance of active engagement for all in the care delivery process (Evens, 1994; Hemmeman, 1995). Power differences between different groups of health care professionals exist during interprofessional working practices in Nepalese hospitals and this may have an impact on how health care professionals collaborate in a team and make clinical decisions.

Health care professionals perceived that education, skills, experience, authority, profession and hierarchies were the major source of professional power in Nepalese hospitals. Interestingly, this has been observed in all hospitals and perceived by all professional groups in the study. Medical professionals hold the leadership roles and medical professionals hold the power, recognition, respect and authority compared to other professionals in Nepalese hospitals. Thus, the findings also complemented by providing results that medical professionals are the unit chiefs and team leaders in Nepalese hospitals and they are engaged and responsible for taking management and clinical decisions. But, there prevailed a contradictory view as well from one of the allied health professionals. He commented that the consensual decision making in interprofessional working seems challenging as different professionals have different languages and different backgrounds. Literature confirms that knowledge is a source of power (Freidson, 1970a & 1970b; Foucault, 1980 & 1986) and power has a great influence in determining professional behaviour and dominance (Freidson, 1970a; 1970).

Nursing and allied health professionals in this study expressed strong opinions for shifting the power from medical to other professions gradually. Few nursing and allied health professionals pointed out the professional identity and recognition of their profession had gradually improved and it might help them by changing the power base in their favour. The majority of the nurses (i.e. 60%) hold the opinion that the situation has now improved and they are happy with the way their identity is recognised and they are valued in the interprofessional care team. Also, there was a common opinion by medical professionals that their profession was well respected, recognised, valued and understood by other health care professionals and the public. However, having higher authority in clinical decision making is not the same as formal team leader roles and different health care professionals assume leadership roles based on professional and personal skills and

the need in specific situations (Christina and Konstantinos, 2009). Literature also suggests that medical professionals perform leading and co-ordinating roles in most of the clinical cases (Lee and Williams, 1994) and most clinical teams and professional groups in health care are led by senior clinicians (Fagin, 1992; Hammeman, 1995; McWilliam et al, 2003; Richardson and Storr, 2010). Bope and Jost (1994) emphasise the medical professional is assumed to be the in-charge or leader of the care team who is responsible for care given by the health care team, although non-medical team members offer advice and render treatment within their professional expertise.

One of the issues raised by this study is the perceived differences in professional power between different health care professionals. Participants indicated that this might arise from differences in expertise, knowledge, authority and hierarchy of an individual or a group involved in an interprofessional care team. Participants (9 nursing, 2 medical and 6 allied health professionals; 6 from the public, 7 from the private and 4 from the voluntary hospitals) raised concerns of lack of training and education for interprofessional working. Most of the participants (9 nursing, 7 medical and 7 allied health professionals) had mentioned that there was no interaction during their university life between health care professionals for interprofessional care. On the other hand it was surprising to observe that the participants felt they were competent and capable of delivering interprofessional care and clinical care to service users despite the lack of training to health care professionals on interprofessional working. As per the findings, the organisational support from the hospitals, regulatory bodies, professional councils, government bodies and universities is very rare or virtually non-existent. It is the nature of the clinical job because medical professionals lead clinical care and it should not stop health care professionals to carry out interprofessional care.

This also shows the prevailing lack of organisational support among the respondents. Interprofessional working is justified in the case of differences in power between different health care professionals as interprofessional working complements expertise and skills of health care professionals. An equal share of professional power is not always required and possible in a practical sense as different professionals have different roles to play in interprofessional care. The research study found that all the allied health professionals mentioned they did not have direct contact with service users most of the time. They are working behind the scenes and did not have responsibilities for making decisions and consultation with service users. It was surprising to find that allied health professionals perceived they have no or very little authority to make decisions for service users. England and Evans (1992) assert the sharing of power should be based on the need of service users or the nature of the task. Barrett and Keeping (2005) suggest that power differentials must be acknowledged, recognised and resolved for effective interprofessional working. If interprofessional collaboration and joint working are all about a 'power sharing game', the professional group with the most power has the most to lose (Engel and Gursky, 2003). In this case, professional groups may not get the equal or fair share of power for making clinical decisions and the effective interprofessional practice would be in the shadows. Barrett and Keeping (2005) state that the ideal shared power could result in everyone assuming someone other than themselves is responsible for following through agreed decisions.

One of the important aspects of professional power is professional autonomy and boundaries between health care professionals, which is linked to control, power, professional dominance and professionalism. Thirteen participants (6 nursing, 4 medical and 3 allied health professionals) believed that their profession was not autonomous as they depend on medical professionals and other health care professionals. Only a few

participants (3 nursing, 2 medical and 2 allied health professionals) linked autonomy with independence and the way they perform their task without any influence or control from other professionals within the health care context. Later, fifteen participants also (8 medical, 3 nursing and 4 allied health professionals) agreed that their profession is autonomous. Along with it, twenty one participants (8 nursing, 8 medical and 5 allied health professionals from 4 the public, 11 from the private and 6 from the voluntary hospitals) experienced that their team leaders were supportive to interprofessional care and they felt that some of the clinical leaders were competent. This study confirms that health care professionals valued professional autonomy. There were mixed responses (i.e. different professions have different levels of autonomy) from participants from different professional groups regarding professional autonomy. This finding seems obvious as the level and intensity of professional autonomy is not the same even within one profession and with an individual professional at different time as it changes with various factors such as roles, responsibilities and competencies. Rawson (1994) states that professional autonomy is achieved through struggle, not simply granted and professionalism is seen as a strategy for closure of professional boundaries (p.47). Coles (1995) asserts that health care professionals tend to work autonomously. Moreover, professional councils advocate that health care professionals are autonomous within their profession. This is due to their differences in roles, nature of clinical tasks and professional roles. Though professional power perspective highlights that an effective interprofessional working may strengthen the power, responsibility or the status of health care professionals and they may gain recognition and status. On the contrary, there is still a question whether increased professional autonomy changes the trend of medical dominance in health care. Kenny and Adamson (1992), argue that changing professional autonomy of allied health professionals has not changed medical dominance in the health service delivery system.

Allied health professionals (7 out of 10 allied health professionals) and nursing professionals experienced limited professional boundaries and interference from other professionals (mainly from medical professionals), whereas medical professionals felt that their professional boundaries were protected. In Chapter 3 of the research, the theory suggests that professional councils set standard for their members by working closely with health care organisations, government bodies and educational institutions to deliver safe and effective health services, to protect service users and to improve clinical practices but the finding brought to light that professional boundaries are not a solid form of concrete walls. They are set by professionals themselves and professional bodies in different forms such as legislations, code of conduct, guidance and standards of practice. To keep the professional boundaries intact, which are encroached by other competitors at different times, health care professionals have to be competent and have to make their professional concerns functionally dissimilar (Leathard, 1994). Evers et al (1994) argue that ongoing maintenance of professional boundaries limits the potential of health care professionals to gain a working knowledge of each other's roles, responsibilities and functions.

This research confirms that health care professionals in Nepalese hospitals experienced changing professional boundaries between various health care professionals in recent years in Nepalese hospitals as other professionals are coming on to the scene in health service delivery. Moreover, it is noted that the autonomy and identity of nursing and allied health professionals are being recognised in recent years. It has been indicated by health care professionals that nursing and allied health professionals are now gradually involved in clinical decision making. As a result, professional boundaries between health care professionals may be changed in the future. McKinley (2000) and Fournier (2000) assert that due to the development of new professions, medical dominance is losing its

grip over other professionals. Pollard et al (2005) mentioned that the drive towards collaborative practice has provided members of other professions such as allied health professionals with an opportunity to raise the status of their own occupational group, and to increase their share of professional power.

This study raises issues of gender and interprofessional care as some participants in this research stated that different genders have different cultures and different levels of power. The majority of the participants (13 nursing, 8 medical and 8 allied health professionals) stated that different health care professionals had different cultures, values and beliefs. Some participants (5 nursing, 4 medical and 4 allied health professionals) highlighted that cultural differences were good for health care professionals and patients. In contrast, five participants (2 nursing, 1 medical and 2 allied health professionals) experienced different negative consequences of cultural differences between different health care professionals. Few nursing professionals in this research commented that the gaps in power, unequal engagement and lack of participation of nursing professionals were due to gender bias in health care in Nepalese hospitals. Nursing in Nepal is still a female profession as only female candidates are eligible for university and college admission into the nursing degrees and courses. As per the study all nurses are female due to a provision that only females are eligible for nursing courses in Nepal. The Government of Nepal introduced 10% of total places of nursing admissions into the University undergraduate programme to male candidates in Nepal in 1986 as a pilot programme, however this was cancelled later in 1990 and only female candidates are eligible for nursing education and training in Nepal (Sigdel, 2011). There is a big difference in gender in the health care industry in general as most physicians are male and most nursing professionals are female, which causes problems with communication (Gray, 1992). Davies (1996) asserts that the job of nurses is less recognised and valued than their counterparts, especially medical

professionals (male dominant profession), which is an example showing that nursing professionals are given lesser importance in health care and are marginalised professionals.

Previous research highlights some gender issues in the nursing profession. Gender stereotypes also consider the types of jobs more suitable for men or women. Traditionally, nursing is seen as a female profession (Evans, 2004) and the number of male nurses is between 5% and 10% of the total registered nurses in the developed world such as UK, USA and Canada (Mullen and Harrison, 2008). Burke (2011) asserts that gender stereotypes, the lack of male role models in nursing profession and misconceptions of nursing professions are the three main reasons why men do not join the nursing profession. O'Lynn (2004) identified few barriers experienced by male student nurses such as feeling unwelcome in clinical areas, differences in behaviours and communication styles between male and female nursing students and fear of accusation of sexual misconduct. Meadus and Twomey (2011) assert that the number of male students entering nursing education has not changed over several decades despite the efforts to attract male nursing students and to introduce greater diversity in nursing education.

Another consideration of gender stereotypes among health care professionals is the existence of a patriarchal social system in Nepal (Gyawali, 2014). Men are primary authority figures in the overall social system and social organisations in Nepal. Therefore, they hold authority over family members and property. This may be discussed in the context of the delivery of health services in Nepal, where doctors are mainly male and they hold authority and decision making power over nursing and allied health professionals. Nurses do not think that they are equally involved in the decision making

process in comparison to other health care professionals, due to the nature of jobs they perform.

Medical and allied health professionals are mainly male professions in Nepal with a large number of male graduates and professionals work in this field. Many researchers report gender stereotypes and unequal social status among health care professionals in an interprofessional care team as some of the barriers to interprofessional working (Norman, 1983; Fagin, 1992; Martin-Rodriguez et al, 2005). Biggs and Schmitt (1983) confirm that power disparity between physicians and nurses prevents nursing staff from collaborating with physicians.

The findings related to professional power perspectives of the theory of professions were discussed in this section. According to Freidson (1970a; 1970b) profession is a source of power and professional power has a great influence in determining professional behaviour and dominance. According to this approach, health care professionals gain professional power from knowledge, training, education, roles and from their interprofessional team and organisations. Health care professionals perceived that education, skills, experience, authority, profession and hierarchies were the major source of professional power in Nepalese hospitals. However, power differences between different groups of health care professionals exist during interprofessional working practices in Nepalese hospitals and this may have an impact on how health care professionals collaborate in a team and make clinical decisions. For instance, nursing and allied health professionals experienced no equal involvement of all health care professionals on clinical decision making and allied health professionals perceived that they have no or very little authority to make decisions for service users.

This study mainly focuses on control over professions, dominance, autonomy and professional relationships. It was perceived that health care professionals influence the

decision making process; but different groups of health care professionals had different views about professional power. It is a unanimous consensus that medical professionals lead the interprofessional team, make clinical decisions and take ownership of decisions. Hence, they greatly influence decision making and delivery of health care.

Further, another theory suggests that professional power of medical professionals comes from autonomy; and they become dominant over other professions (Freidson, 1970a). This observation can be supported by various findings of the study. It is concluded that medicine is the most established and dominant profession amongst all professions in the context of Nepalese health care. Health care professionals believed that it is due to their roles, education, knowledge, expertise and hierarchical organisational structures; and the respect and recognition they receive from the public and other professionals in Nepal. It has been stated by nursing and allied health professionals that domination is a usual practice by medical professionals and medical professionals are perceived to be more autonomous than other professionals. Furthermore, medical professionals mentioned they are autonomous, there is no interference observed in their work. Whereas, most of the nursing and allied health professionals felt they are not autonomous. Lastly, health care professionals felt professional boundaries between health care professionals are changing. Nursing and allied health professionals are getting more recognition.

7.4 Interprofessional Working and Clinical Governance

This section discusses the key concept of interprofessional working and findings of this study within a clinical governance framework and the delivery of safe patient care. This section discusses various practical ways of implementing the clinical governance framework within interprofessional working and collaborative practices. This section also links the concept of interprofessional working with interprofessional education and learning for the safe and effective delivery of health care.

Clinical governance is defined as a mechanism through which 'health services are held accountable for the safety, quality and effectiveness of clinical care delivered to patients' (NHS Scotland, 2007). This has been described as an 'umbrella term' by the Royal College of Nursing (2003) to deliver high standards of care, to continuously improve the health services and to maintain high standard of care and experience. Different groups of health care professionals work together, and they are an integral part of the health and social care system. They are subjected to regulation, compliance, national and local policies, guidance, protocols and accountability arrangements for patient safety, clinical effectiveness and improved service users' experience. Quality is the heart of health services and quality in relation to clinical governance is defined in three broad strands – patient safety, clinical effectiveness and patient experience (Department of Health, 2008).

According to Winter (1999), clinical governance is 'a systematic approach to assure the delivery of high quality health services with the active participation of clinicians and patients supported by managers'. Winter highlights the involvement of clinicians, joint working and the support of health care managers to make them accountable for ensuring the standards of patient care. The definitions above illustrate that health care professionals need to work together to deliver safe and high quality health services. The Royal College of Nursing (RCN, 2013) states '*clinical governance aims to improve the quality of care through strengthening existing systems, delivering evidence-based practice and encouraging a training and development culture*' (p.5). Clinical governance is a continuous process for improving and sustaining the quality of care delivered to service users. Clinical governance ensures clinical quality is placed at the heart of the health services by the joint efforts of health care professionals for the delivery of the highest standards of care by reducing failures and shared learning.

The Clinical Governance Support Unit (2008) develops a clinical governance framework and asserts that the ultimate aim of clinical governance is to deliver high quality of care by promoting safety, and a no blame and open culture. It further illustrates that communication, leadership, patient involvement and high quality data are the foundation of clinical governance; whereas clinical effectiveness, risk management, patient focus, interface between services, professional self-regulation, continuous professional development and research and development are mentioned as the pillars of clinical governance. It describes clinical governance as a mechanism for improving the quality of health services.

Nicholls et al (2000) assert that patient - professional partnership, effective communication, teamwork, ownership, leadership, risk management, resources and strategic effectiveness, patient experience and learning awareness are major components of clinical governance. Some of these components such as leadership, communication, ownership, partnership, sharing expertise and learning are mentioned as essential elements for successful interprofessional working (Wells et al, 1998; Way et al, 2000; Carnwell and Buchanan, 2005). The clinical governance model focuses on the utilisation of resources, leadership, open communication and teamwork for patient safety, clinical satisfaction and patient experience through shared learning and strategic approach. Walshe (2000) highlights the importance of leadership in clinical governance and asserts that transformational leadership is an appropriate choice for the implementation of clinical governance agendas in health care organisations. The performance of an interprofessional team cannot be easily achieved without the leader, who is the one to drive, motivate and inspire team members to achieve the common goal of an interprofessional care team (Zaccaro et al, 2009).

An organisational framework including structures and systems for clinical governance at an organisational and team level is required to make improvements as envisioned by clinical governance framework (Lugon and Seeker-Walker, 1999). Organisational structures directly and indirectly influence interprofessional care and team outcomes (Pina et al, 2008; Odegard, 2005; Glasby and Dicknson, 2008) and teams cannot function without a clearly defined organisational and team structure (Baxter, 2007). The Department of Health (1998) describes that the clinical governance model sets standards to make sound clinical judgements and to work together effectively with health care professionals for the delivery of high quality health services.

The implementation of clinical governance agendas is also important alongside developing strategies and policies. The clinical governance framework, policies and plans remain on paper without a proper system for implementing them for the benefits of health care professionals, organisations and service users. The Royal College of Nursing (RCN, 2013) states supportive culture, equity and consistency of services, quality at the centre and partnership in care are the four main principles of the implementation of the clinical governance agendas in health care organisations. The Department of Health (1999d) has outlined the following principles for the implementation of the clinical governance agendas:

- Establish leadership, accountability and working arrangements;
- Carry out a baseline assessment of capacity and capability;
- Formulate and agree a development plan in the light of this assessment;
- Clarify reporting arrangements for clinical governance within Board and Annual reports.

(Department of Health, 1999d)

High quality care means safe and effective care with positive experience for service users (National Quality Board, 2011). Health care organisations are responsible for the quality of care they deliver to service users. It is the responsibility of health care professionals to recognise their roles in providing high quality care and sharing good practices (Leathard, 1994). According to Norman (1985) health care professionals are responsible for developing interprofessional care competencies and delivering safe and effective health services. Professional self-regulation is the key feature of true professions (Freidson, 1970a). It also remains an essential element for successful interprofessional working and for delivery of high quality care. Clinical governance promotes a learning culture and develops a system to deal with and learn from incidents, claims and complaints, and to identify and manage risk in health care organisations. Moreover, it links national standards with local protocol and guidance, and defines external and internal systems of accountability for health care professionals and organisations.

Patient safety is of great importance to health service users and it cannot be compromised at any cost. Clinical effectiveness is measured in terms of effectiveness of services provided to service users. Clinical audit measures clinical practices against national and local standards. Health care professionals play vital roles in the implementation of interprofessional working and clinical governance agendas for many reasons. It can be concluded that the clinical governance framework ensures health services are patient-centred and it focuses on achieving the highest possible care being delivered to service users. Some key and common features of clinical governance and interprofessional working ensure successful collaborative practices, safe and effective delivery of health services.

The findings of this study are associated with principles, practices and framework of clinical governance and improving the quality of care in health care organisations as

discussed above. Health care professionals in Nepalese hospitals under the study perceived that interprofessional working in hospitals improves the quality of care, staff satisfaction, team performance, communication and interaction. The participants stated that the importance of interprofessional care team leaders is evident in improving the quality of health services and for successful interprofessional working.

The participants perceived poor communication creates conflict and problems in care such as increased numbers of clinical incidents, misunderstanding and confusion. Most of the participants confirmed they used verbal means of communication and used written forms and mostly medical notes to communicate with other health care professionals. One of the important points raised by the participants was communication with service users. This study confirms that health care professionals in Nepalese hospitals are skilled in communicating with other health care professionals despite a lack of training and proper mechanism.

Health care professionals stated that they valued service users' involvement in interprofessional care and believed that service users' awareness of their problems and understanding issues from their perspectives are important. This study confirms that service users' involvement in health care delivery improves informed consent and compliance for their treatment plan, management and care. The participants confirmed that interprofessional working enabled them to learn skills and knowledge by working with other professionals. Health care professionals perceived themselves as being empowered when they are equipped with interprofessional care skills. Some participants stated that the lack of skills and competencies for interprofessional working has implications on interprofessional working practices. Few participants realised that interprofessional learning is a continuous process which starts in the early stage of student life and continues at the professional practice level in health care settings.

This study confirms that all hospitals under study in Nepal have no organisational policies for interprofessional working and for the involvement of service users. Few participants stated that awareness of roles, being honest with oneself and understanding others help to make interprofessional relationships strong. The participants perceived that shared learning and learning by working together is widely practised in Nepalese hospitals and is perceived as the best way of learning interprofessional skills and competencies. They further stated that interprofessional education and learning is required for successful interprofessional working.

Clinical governance is about the delivery of high quality care which cannot be achieved without teamwork and collaborative practices (Hallett and Thompson, 2001). The successful development and implementation of interprofessional care in health care organisations are dependent on, but not restricted to, many professionals, people and organisations such as health care regulatory bodies, health care professional organisations, academic institutions, hospitals, community and support agencies, health care staff and professionals, researchers, service users, government, health caregivers, educators and administrators (HFO, 2010). The main aim of these stakeholders is to deliver effective health care and to satisfy service users without doing any harm through interprofessional collaborative practices. Therefore, interprofessional working is directly linked to clinical governance in terms of improving the quality of care, patient safety, clinical effectiveness and service users' satisfaction. Clinical governance plays a vital role in improving patients' experiences, decreasing disparities in healthcare and shared learning from the experiences by promoting openness and culture of accountability. High quality of care leads to professional pride and it focuses on improving health services by energising and motivating all health care professionals and staff (Department of Health, 2008).

If a health care team fail to deliver, the quality of care deteriorates and it has direct impact on the care of service users (Stonehouse, 2011). The benefits of interprofessional working such as improved standard of patient care, patient safety and improved patient outcomes are widely cited in the literature (Yeager, 2005). Other benefits such as increased patient satisfaction, preventing fragmentation of care by introducing and applying holistic approaches to care are also cited by research scholars (Haward et al, 2003; Vazirani et al, 2005; Atwal and Caldwell, 2005). Interprofessional working is essential for the survival of a health care organisation (Petri, 2010). Similarly, the importance of clinical governance for a healthy health care organisation, for safe patient care and satisfied service users is highlighted by Swage (2005).

Collaborative leadership is one of the major contributing factors for successful interprofessional working in hospitals (Chong et al, 2013). Similarly, successful implementation of the clinical governance agendas within the health services depends on leaders who are able to inspire and motivate other professionals (Swage, 2005). The role of leadership in interprofessional working is performed usually by the participants in order to drive the interprofessional working agenda forward and the leaders of interprofessional working teams are guided by policies, protocols, guidance and standards. Stonehouse (2013) asserts that the implementation of the clinical governance agendas require positive and strong leaders at every level. In this context, health care leaders should be able to drive both the clinical governance and interprofessional working agendas together for safe and effective clinical care.

Communication is '*an integral ingredient for the success or failure of clinical governance*' (McSherry and Pearce, 2011, p.143). Different authors and research scholars have mentioned various reasons why communication plays a vital role in interprofessional working and clinical governance; for example as it helps to

communicate goals, purposes and outcomes (Evans, 1994); shares important and useful information (D'Amour et al, 1999); supports the negotiation between different groups of health care professionals (Mariano, 1989); and helps to build mutual respect and trust (Hemmeman et al, 1995). Various research have showed that poor communication and relationships between health care professionals can be harmful to service users and result in increased rates of clinical incidents and errors (Larson, 1999; Espin & Lingard 2001, Lingard et al, 2002; The Joint Commission, 2002; Manser, 2009). The lack of communication and co-ordination between health care professionals is seen potentially to be a serious factor in compromising good care.

There is a direct correlation between successful interprofessional care teams and quantifiable service improvements in patient safety and the quality of delivery of health services (The Joint Commission, 2002; Institute of Medicine, 2001). In order to improve the quality of health services, health care professionals are required to follow an interprofessional working approach. A single health care professional or groups or professionals working in an un-coordinated way cannot achieve the aim of effective delivery of health services. Health care professionals deliver coherent, effective and accessible services to service users through interprofessional working and implementing the clinical governance agendas in health care organisations which can be a common platform for all stakeholders.

One of the objectives of interprofessional working is to reduce clinical incidents and to improve patient safety and there is evidence that effective interprofessional working improves patient safety (The Joint Commission, 2005). Health care professionals in interprofessional care teams are required to share common perspectives on patient safety and improving the quality of care by promoting a non-punitive and non-blaming team culture and negotiating their roles with other health care professionals. Authenticity of

communication is important in clinical care to avoid patient safety incidents. Therefore, written forms of communication and protocols for interprofessional working and clinical governance are preferred to avoid confusion and miscommunication.

Communication to service users and among health care professionals refers to aspects of openness, style and expression of feelings and thoughts (Interprofessional Education Collaborative, 2011). The means and ways of communication are directed towards various aspects of interprofessional working and clinical governance. If health care professionals are ready to help service users, it is vital that they convey and communicate their feelings about the situation of a service user and each others' input in a meaningful way (Department of Health, 2004). Service users and health care professionals can influence each other in the delivery of health services. Quality of interaction and communication among health care professionals and between service users may also influence the decision making process. Hornby and Atkins (2000) assert that the relationship of a health care professional with service users is also based on training and experience and the balance of power is more on the side of health care professionals.

Interaction, open listening and communication are collaborative skills required for health care professionals (Norman, 1985) to implement the clinical governance agendas for the successful delivery of health care (McSherry and Pearce, 2011). Open communication is all about passing appropriate information without any barriers and defensive methods which can be easily understood and assimilated by service users. Open communication promotes transparency and patient safety in health service delivery and helps to improve the quality of care (The Joint Commission, 2002).

Service users are at the heart of interprofessional care and collaborative practices (University of British Columbia, 2008) and quality improvement process (Department of Health, 2008; Stonehouse, 2013). The existence of health care professionals is for

service users. Health care professionals need to engage, involve and listen to service users and act upon comments, feedback and experiences of their service users in order to deliver and improve health services. Health care professionals have different responsibilities and accountabilities for making contact with service users and clinical decision making. Lord Darzi's report 'High Quality Care for All' (Department of Health, 2008) highlights that service users' experience is one of the key components of high quality of care.

Health care professionals are responsible for updating with recent developments and learning skills to improve safe and effective clinical care (Stonehouse, 2013). Interprofessional care empowers health care professionals (Canadian Medical Association and the Canadian Nurses Association, 2006) and empowered professionals improve the quality of care and patient safety (Department of Health, 2008). Maximising nurse - physician collaboration holds promise for improving patient care and creating satisfying work roles (Lindeke & Sieckert, 2005).

A team cannot succeed unless its members are able to contribute three types of skills and experiences: problem-solving and decision making skills, technical or functional expertise, and interpersonal skills (Natale et al, 1998). Interpersonal and communication skills are fundamental skills for interprofessional working (Minore and Boone, 2002). The lack of communication skills is one of the major contributing factors of patient safety incidents in health care (The Joint Commission, 2002).

Continuous professional development, regular review and reflection of clinical practices are important components of clinical governance (White, 2015). One of the important aspects of clinical governance is learning from complaints and adverse incidents (Stonehouse, 2013). Continuous professional and skill development for health care professionals in areas such as communication, change management, teamwork and

leadership is important to the successful operation of interprofessional care teams (ECIP, 2005). Strong support from management, adequate resources and appropriate structures for health care teams and clinical care are required to improve the quality of care, patient safety and patient experience. Furthermore, different health care professionals have different capacities and different capabilities for different health care settings, based on their skills, competencies, familiarities and comfort levels. Mu et al (2004) argue that many health care professionals do not have adequate understanding of other colleagues' roles due to the lack of adequate training and education in interprofessional skills.

Organisational and clinical policies, protocols and guidance are the best means of ensuring clinical effectiveness, which is an important component of clinical governance (White, 2015). It ensures that everything health care professionals do is meant to provide the best outcome for service users by adopting an evidence-based approach and doing the right thing to the right person at the right time and in the right place (National Quality Board, 2011). Policies and protocols for interprofessional working are important elements to support collaborative practices. Local, national and organisational policies and clinical protocols are required for the safe delivery of health services.

Transparency and accountability are two pillars of clinical governance (Scally and Donaldson, 1998; Bloor and Maynard, 1998). Openness ensures that healthcare professionals develop a culture of sharing information and knowledge; and learning from mistakes in their clinical practices in healthcare organisations. The true openness includes the sharing of practice and experience that 'went wrong', with the intention of learning on how to improve the services and not to repeat the same mistakes in the future. It is important to note that interprofessional relationships are not developed overnight and it may be developed gradually over a time period between health care professionals. Mutual trust and respect are important factors for supporting interprofessional working in health

care and it depends on experience, skills and knowledge of health care professionals (Henneman et al, 1995). Henneman et al further assert that it requires time, effort, patience and experience. Literature suggest that health care professionals trust more experienced and competent professionals in actual clinical practice and this helps to deliver safe patient care (Baggs and Schmitt, 1997). Mutual trust is important while performing a particular task in health care. Robertson (1992) argues that health care professionals must trust other professionals' judgement about whether and how to implement advice from various sources. A clear line of responsibility and accountability for safe, effective and efficient delivery of health care is required at all levels. The lack of accountability in the health services is one of the contributory factors for failure of effective and efficient health services in Nepal (Kaini, 2013). The clinical governance process ensures that service providers are liable, responsible and answerable to tax payers, service users and all stakeholders.

Health care is one of the biggest industries and shared learning is vital to deliver an efficient health service to service users. Through the shared learning process, health care professionals learn from each other and discover something about themselves and other colleagues (Milburn and Walker, 2009). Health service delivery is an interactive process and requires coherent and aligned efforts to continuously review roles and responsibilities of health care professionals. Sullivan (1998) says that collaborative learning can be the best opportunity to transfer the diffused educational efforts of the diverse health care professionals into a powerful unified force.

The elements that must be in place before interdisciplinary collaboration can be successful are interprofessional education, role awareness, interpersonal relationship skills, deliberate action and support (Petri, 2010). Teaching teamwork skills and team concepts should become a significant part of medical and nursing education and training

if we want to achieve a substantial improvement in the quality of health care services, especially in high risk areas such as an intensive care unit (Kydona et al, 2010). Educational experiences and the socialisation process that occur during the training of each health professional reinforces the common values, problem-solving approaches and language/jargon of each profession (Hall, 2005). According to Pype et al (2013), knowing each other's expertise is not sufficient, but health care professionals need to learn and enhance role specific competencies. Interprofessional education, practice and research can have economic benefits and effective clinical outcomes, which may be viable means for improving health care delivery (Paul and Peterson, 2002).

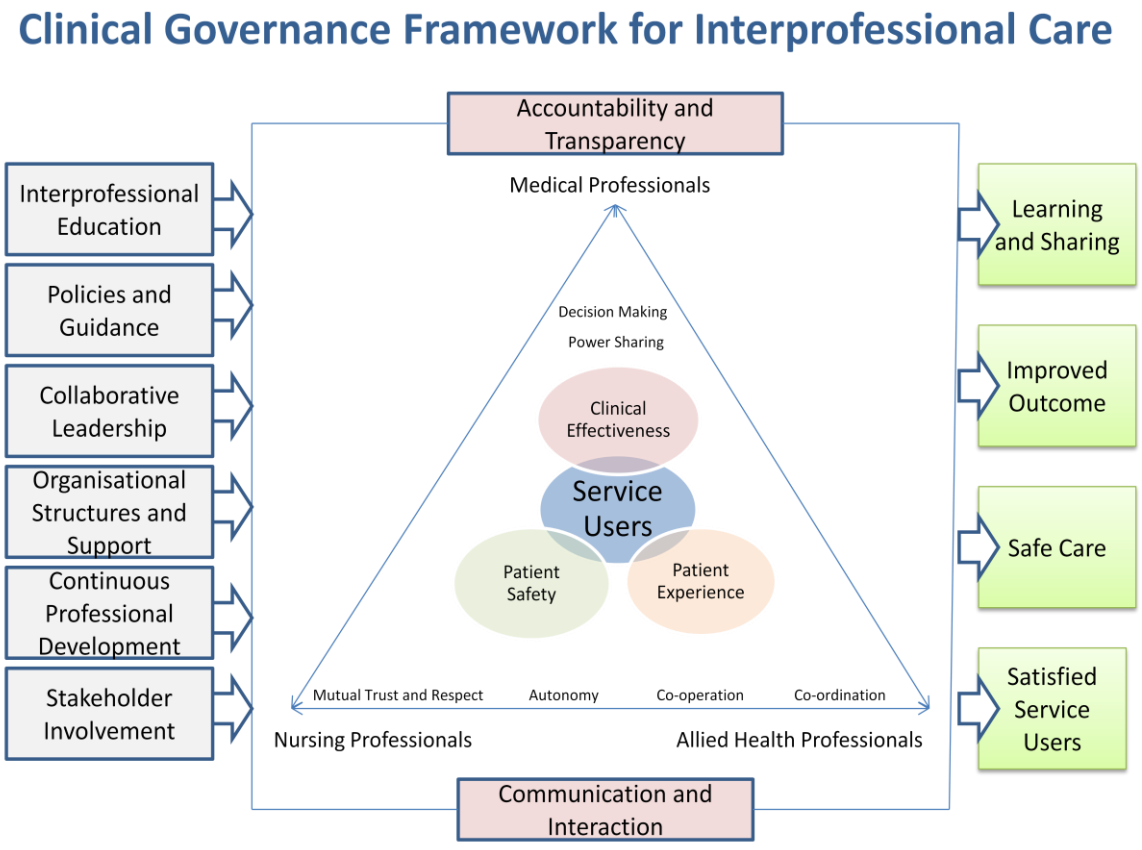
According to Firth-Cozens (1999) risk management, change management, team dynamics, clinical audit, professional development and training are the major areas for development in terms of developing competencies required for health care professionals in implementing the clinical governance agendas. The major elements of clinical governance are seen as fragmented (Department of Health, 1999d) in contrast to the holistic approach of health service delivery in interprofessional care (Rafferty et al, 2001). The holistic interprofessional working system offers quality and comprehensive health service to health service users by different health care professionals in a systematic way (CIHC, 2009).

Clinical governance is everyone's business and it is not an optional provision for health care professionals and organisations. Therefore, every health care organisation should have proper systems and structures for clinical governance at all levels. Leaders and management should ensure they take clinical governance and interprofessional working agendas forward together. Moreover, health care organisations need to provide adequate resources in terms of funding, training, education, time and structures.

In summary, this study confirms that interprofessional working promotes shared decision making, mutual trust, respect, co-operation, co-ordination and learning from each other. Clinical governance is a framework for improving the quality of care and access by increasing accountability and promoting transparency for the excellent outcome of health care, shared learning and sharing. The concept of clinical governance and interprofessional working are inseparable from the health services and both concepts complement each other for safe and effective delivery of health care by working health care professionals together.

As discussed above, the following clinical governance model for interprofessional care summarises the relationships between interprofessional working and clinical governance in health care. It also highlights the importance of interprofessional education, training and learning for improving the quality of care and interprofessional working.

Figure 9: Clinical Governance Framework for Interprofessional Care



The scope and principles of interprofessional working go beyond simply meeting different health care professionals under one roof. Various health care professionals, disciplines, roles and organisations are involved in the process of interprofessional working and clinical governance. Health care professionals are skilled and trained in their clinical fields and they work together with other professionals, service users and families to share their knowledge, skills and expertise and serve the service users. In terms of clinical governance, the scope of health care professionals work is wide and it includes developing appropriate structures, policies and guidance, agreeing on approaches to enhance skills and sharing knowledge for patient safety, clinical effectiveness and patient experience.

The demand for health services and health care professionals in developing countries is increasing at a rapid pace due to various reasons such as population growth and the growing number of elderly people. Moreover, new ways and clinical practices are emerging in light of the development of new technologies and the emergence of new specialties and sub-specialties. Therefore, developing an interprofessional working culture and practices, interprofessional care teams and workforces in developing countries can help to improve the quality of care, patient safety and experience.

Chapter 8: Conclusion and Recommendations

8.1 Introduction

The previous chapter focused on the discussion of the findings in relation to interprofessional working and professional power perspectives of the theory of professions. This chapter summarises key findings of the research and presents the conclusion of the study. This chapter recommends ways for improving interprofessional practices in Nepalese hospitals. The contributions made to the knowledge are discussed and presented in this chapter to confirm whether this research is capable of yielding significant insights into interprofessional working and making a major contribution to knowledge. Moreover, this chapter discusses the limitations of the study so that the findings can be presented, interpreted and discussed in a certain context or boundaries of the study. Finally, this chapter suggests further research in the field of interprofessional working practices.

8.2 Key Findings and Conclusions

The findings from the research suggest that the discipline of interprofessional working is widely understood, recognised and valued by health care professionals in Nepalese hospitals. However, the organisational support for interprofessional working from the hospitals, regulatory bodies, professional councils, government bodies and universities is very rare or virtually non-existent. Participants recognised the role of clinical leaders and senior management in promoting an interprofessional working culture; and developing sound structures and policies for collaborative practice. The findings suggest that health care professionals carry out different roles, values, status and responsibilities in terms of delivering interprofessional care. It depends on the clinical nature of their job, other responsibilities, and type of team they are involved in. This research identifies that health

care professionals use verbal means of communication most of the time. Other common forms of communication are medical notes, team meetings and memos or internal forms of communication.

This research suggests awareness of service users of their problems and understanding their perspectives are important and involving service users is valued by health care professionals. However, there was a great variance in the perceptions of health care professionals in terms of involving service users in clinical decision making. This research identifies that health care professionals recognise and value the expertise in interprofessional care and the separate and shared knowledge and skills of all health professionals that leads to a participatory, collaborative and co-ordinated approach to care for service users. This study shows different sides of power, gender and cultural differences in medical, nursing and allied health professionals. This research identifies that health care professionals have different values and cultures and they understand the value of respecting the culture of other professionals. It can be concluded that nurses and allied health professionals are more critical to the medical professions because they feel dominated and professionally isolated from the medical professionals. This research suggests that dominance of medical professionals exists in Nepalese hospitals. The reasons for medical dominance identified are education, expertise, social recognition, roles and hierarchy. Moreover, participants felt that boundaries of health care professionals are changing and the roles of nursing and allied health professionals are also gradually recognised. There were consistent findings across all the three hospitals and among all health care professional groups of the benefits and importance of interprofessional working for service users, health care professionals and health care organisations. Participants perceived that interprofessional care helped to avoid duplication and gaps in care. Furthermore, they perceived that interprofessional working

helped to improve quality of care, staff satisfaction, team performance interaction and communication.

It is concluded that health care professionals do not have significant contact with one another during their formal or university education in Nepal. It is obvious that if health care professionals do not have contact with each other for a long period of time, they become unfamiliar with the professional skills, capabilities, expertise, competencies and principles of the other. It is concluded that interprofessional working is not sufficiently motivated amongst health care professionals and adequate appreciation is lacking from all stakeholders in the Nepalese context.

This study identifies some barriers to interprofessional working in Nepalese hospitals. Participants mentioned various organisational, professional and interpersonal barriers to achieving a shared goal of interprofessional working. The most commonly stated barriers are lack of education and training, lack of protocols and guidance, poor interprofessional and communication skills, medical dominance, ego, negative attitude, no respect for others and a high workload. Despite this, it is evident that there were great examples of enthusiasm and passion for interprofessional working for the effective delivery of health services. This study suggests that health care professionals can learn skills and competencies for successful interprofessional working at work.

This research suggests various ways of improving interprofessional working in Nepalese hospitals. It is the responsibility of health care organisations to develop interprofessional policies, principles, roles, responsibilities and competencies for health care professionals and to make sure that health care professionals apply these in practice for the delivery of effective interprofessional care in hospitals. Health care professionals suggested that learning from each other, provision of interprofessional learning, training and education; promoting a culture of open and effective communication; developing a proper system

and structures for interprofessional working help them to improve interprofessional working practices between health care professionals.

8.3 Recommendations for Improving Interprofessional Working

As discussed in the previous chapters and sections, this research identifies the issues, challenges and barriers of interprofessional working. This study also recommends various ways for improving interprofessional working in Nepalese hospitals to bridge the gaps in practice, which can be categorised into five broad headings; policies, training and education, clinical leadership, organisational structure and support, and use of appropriate means of communication and interaction; and these are discussed in the following sub-sections.

8.3.1 Policies and Guidance

Health care professionals and organisations have to agree and develop policies, guidance, protocols and practices for interprofessional working. Health care professionals, organisations, professional and regulatory bodies, educational establishments and clinical leaders should work together to develop and agree on policies and standard operating protocols for interprofessional working. The joint planning, consultation, working and regular communication between hospitals and universities are vital for developing national and local policies for interprofessional working. Health care professionals also have to listen and engage in discussions within an interprofessional team and with other stakeholders for developing interprofessional care protocols. This helps to develop proper guidelines, policies, protocols, system, structures and interprofessional culture for interprofessional working. Moreover, the local policies have to be linked with the national policies for interprofessional learning and working. The national and local

policies and protocols for interprofessional care and teamwork should be supported by legislation and should be financially resourced (Engel, 1994).

Health care organisations have to disseminate interprofessional working policies to every member of interprofessional care teams and to all stakeholders. They also need to create awareness about the policies and protocol so that every health care professional can familiarise with the existence, purpose and intent of these procedural documents. Furthermore, these policies and protocols have to be consistently and universally implemented and applied across health care organisations and there has to be regular monitoring and evaluation of the practices. The implementation of such protocols is, however, largely dependent on commitment and willingness of hospital management and active clinical engagement from all health care professionals. Good communication, policies, guidance, protocols and effective mechanisms are required to resolve tensions and conflict when they arise (Baldwin and Daugherty, 2008). D'Amour et al (1999) confirm that formal policies and procedures for interprofessional care teams play important roles for the development and successful implementation of interprofessional working.

Health care organisations and interprofessional care teams are required to regularly review interprofessional working protocols so that changes can be made based on the lessons learnt in the past for successful interprofessional working practices. This approach helps to take corrective measures, to change interprofessional working protocols based on the feedback received from stakeholders and to adopt a shared idea to improve interprofessional working, communication, interaction and collaborative practices. This may lead to a more successful, effective and co-ordinated health care system.

8.3.2 Training and Education

It has become clear from the findings of this study that health care professionals are never trained or educated formally on interprofessional working in Nepal. It is evident from the review of organisational polices of the three hospitals under study that there were no organisational resources for this type of training, interprofessional education and learning. Therefore, health care organisations and educational institutions are required to allocate enough resources, develop and set up interprofessional training, education and development for all groups of health care professionals

It is important to review the current education practices and policies on interprofessional working and learning within all universities and educational establishments. To achieve this aim, there has to be regular and open interaction between health care professionals at the professional level and proper discussions, links, partnerships and networking between educational establishments and health care organisations are required. This has to be done through an interprofessional lens and multi-sector or organisations initiatives.

It is also important to develop and share interprofessional learning and educational curricula, materials and tools for all health care professionals in all educational establishments. Apart from the clinical practices and interdisciplinary topics, generic topics such as communication skills, negotiation skills, interpersonal skills, assertiveness, diversity and equality, conflict management, stress management, team development and management skills, interpersonal skills and social organisation skills can be included for all groups of health care students at different specialties or departments. It is always a good idea to pilot training programme at a few hospitals, then gradually implement them at different phases across the country in all hospitals.

Students from nursing, allied health professionals and medical schools should be taught other areas of expertise. For this, educational materials, courses, modules and training should be shared across all disciplines. Appropriate contents and educational materials should be included in the curriculum. Sullivan (1998) states that relationships among and between health care professionals and their knowledge, skills and expertise, and relationships between health care professionals and the patients must be 'made and sustained'.

Competency assessment on a regular basis helps to assess skills and competency of a health care professional and develop further professional development plans for improving their proficiency (Barr, 1998). Competency training can be organised at each hospital to give them updates and to enhance their knowledge, skills and competency. The health care organisations, professional councils and associations can work together and join hands to support health care organisations, to develop these training programme and to implement them across all health care organisations.

Continuous professional and skill development for health care professionals in areas such as interdisciplinary clinical practices, communication, change management, teamwork and leadership is important to the successful operation of interprofessional care teams (ECIP, 2005, p.5). Strong support from management, adequate resources and appropriate structures for interprofessional learning, education and working are also required for effective interprofessional care teams to achieve goals and optimal desired outcomes.

Health care professionals are required to look at their boundaries, should be aware of their own profession, familiar with the problems of service users, and the roles of other stakeholders to deliver successful interprofessional care. Therefore, they have to identify the capabilities required to work within their professions and other professions who work with them. They need to develop the skills, knowledge and expertise that extend beyond

the conventional means of learning based on a field. Different groups of health care professionals who work with other professionals within a single discipline can develop common interpersonal skills and the professional expertise required to deliver effective interprofessional care through interprofessional education.

8.3.3 Clinical Leadership

This research suggests that interprofessional care team leaders can support health care professionals by promoting trust, respect and effective communication; and by enhancing the skills of a team member, to enable them to participate in decision making. Leaders do not achieve team goals by themselves (Callaghan, 2006), it can be achieved by joint working and this can influence the team performance (West, 2002). This research highlights that it is really important how much the interprofessional care team leader supports and cares for their concerns, which can make a huge difference in clinical outcomes and improving quality of care.

Needless to say, health care leaders play important roles to guide all members of the professional team to ensure they are fulfilling their roles, building morale and fostering creativity. The roles to play by an interprofessional care team leader vary according to the nature and scope of the team and service users. Sometimes they may need to focus on one aspect and sometimes others. For instance, communication with colleagues may be on top of the list, making clear what they want to do and making decisions may be prioritised. However, interprofessional care team leaders need to play all of these roles effectively in an interprofessional care team for the effective delivery of health services.

Each hospital or clinical department can have one nominated ‘interprofessional champion’ to support, educate and mentor other health care professionals. The ‘interprofessional champion’ can act as a resource person for developing a proper culture

and environment for interprofessional working; and a facilitator for the interprofessional working. It is the responsibility of health care organisations to support interprofessional care team leaders and equip them with the appropriate levels of skills and competencies required to lead interprofessional care teams. Health care organisations can work with educational institutions to develop clinical leadership development programme at organisational and national level. Clinical leadership is essential for the delivery of interprofessional care and development of inter-organisational collaboration (D'Amour et al, 2008).

The clinical team leader is also a member of the interprofessional care team. It is the responsibility of the clinical team leader to make sure the health care professionals work together to implement interprofessional working agenda and to achieve their common goals of delivery of effective health services to service users. Health care organisations and team leaders need to make sure that there are enough resources for interprofessional learning, education and working. Clinical leaders should also play pro-active roles for improving clinical engagement for effective interprofessional working in hospitals.

8.3.4 Organisational Structures and Support for Interprofessional Working

After a thorough analysis of different aspects of interprofessional working, it is important to look at organisational aspects (such as structures, system, process and leadership) of interprofessional working. People are the vital resources and assets of an organisation and interprofessional care team members shape the future of an organisation. Health care organisations play important roles to develop and support interprofessional working. O'Daniel and Rosenstein (2008) assert that interprofessional working requires a favourable environment, organisational structures and settings such as administrative support, proper organisational structures, sound philosophy, resources, communication and co-ordination mechanism. Engel and Gursky (2003) argue that if interprofessional

working is to be a priority of the health care organisations and health care professionals, they need to develop ways for continuous discussion and agreement about a system that is right for all.

Health care organisations should define the roles of health care professionals and expectations of service users in local policies and procedures so that health care professionals can be supported in enhancing their skills and capabilities by providing them with the right level of training, supervision, guidance and mentorship. Health care organisations are required to define roles, responsibilities and accountabilities of health care professionals in terms of interprofessional working practices. Interprofessional working is an integral part of professional life for all health care professionals. Health care organisations are required to create the right opportunities for training and to develop a support system in each health care organisation.

Interprofessional working is an ongoing process between health care professionals. It is neither a one-off work nor a project with a certain life. Therefore, the membership or structure of interprofessional care teams is fluid and evolves over time. In this context, it is important to provide a strong strategic approach and organisational support to embed effective interprofessional working practices at each hospital. This has to be matched with the allocation of appropriate resources for interprofessional learning and working. Hospitals can fully develop successful interprofessional working practices to provide assurance, direction and support to all stakeholders involved in this process. It is usually the clinical in-charge who takes accountability for the clinical decisions. Ultimately health care organisations are held accountable for the decisions made by their employees. Therefore, it is the responsibility of health care organisations to make sure health care professionals are equipped with all the skills and professional capabilities for successful interprofessional working.

Health care organisations need to develop a system and process for interprofessional working practices across traditional organisational structures. In this case, health care professionals and interprofessional care teams can perform appropriate planning, assessment and management to co-ordinate health care delivery for service users. Health care team structures are the pillar of health care organisations, creating hierarchies and a support mechanism for interprofessional care and collaborative practice (Enderby, 2002). Health care managers play crucial roles in developing organisational strategies, prioritising resources, planning and managing health services. Therefore, they need to be aware of all aspects of interprofessional care, so they can allocate appropriate resources for interprofessional care. Successful interprofessional working is essential for the effective delivery of health services. Therefore, health care organisations are required to provide the right support and professional developmental opportunities to health care professionals.

8.3.5 Communication

Communication is one of the major components of interprofessional working in a health care setting. This research highlights poor communication between health care professionals as a major barrier of successful interprofessional working. This has been identified as an important area for improvement for the effective delivery of health care. Therefore, health care organisations are required to develop a framework for communication and interaction between health care professionals in a clear way, so roles and responsibilities are clearly defined. Health care professionals are also required to use respectful and appropriate means of communication so that a full disclosure and transparency in all interactions with others can be made. Moreover, health care organisations should promote a culture of mutual respect, equal involvement and trust.

One of the ways to enhance interprofessional working is by regularly getting together in the form of formal or informal meetings and interactions. This helps to encourage open dialogue, interprofessional briefings and collaborative practices (O'Daniel and Rosenstein, 2008). Furthermore, creating a favourable environment for open and transparent communication is equally important. Other ways to make communication and interaction effective for interprofessional working are the provision of guidelines or protocols, team meetings, continuous medical education (CME), ward rounds, clinical conferences and face-to-face discussions. It is the responsibility of health care organisations to create opportunities and favourable environments for these types of interactions and collaborative practices among health care professionals.

Health care professionals engaged in interprofessional working recognise the need to be clear about lines of communication, management and accountability as these may be more complex than in their specialist area. The Health Professions Regulatory Networks (2008) asserts that health care professionals must also be accountable for and committed to maintaining effective communications with other members of the interprofessional health care team, and promote team problem solving, decision making and collaboration by applying principles of group dynamics and conflict resolution.

8.3.6 Summary of Recommendations

In summary, the following points are recommended to improve interprofessional working practices in Nepalese hospitals:

- Health care organisations are suggested to develop formal policies, protocols and guidance on interprofessional working

- Health care organisations, educational institutions and professional councils are suggested to work together to offer appropriate training and education on interprofessional working
- Health care organisations are suggested to develop a strong clinical leadership to implement and support interprofessional working agenda
- Health care professionals and organisations are suggested to promote a culture of open communication and proper interaction between health care professionals
- Health care professionals and organisations are suggested to develop a culture of mutual respect, equitable involvement and trust
- Health care organisations are suggested to offer appropriate support to develop a culture of interprofessional working

Finally, it is recommended that all health care organisations take an interprofessional working approach, develop sound culture of collaborative practices and commitment to support, align and embed new programme to improve and support interprofessional working for effective delivery of health services.

8.4 Contribution to Knowledge Made by this Research

The importance of interprofessional working has been documented within a wide range of health care settings and teams including: maternity (Crozier, 2003), primary care (Shaw et al, 2005; Dianne et al, 2008); GP practices (Dent & Burtney, 1996; Hansson et al, 2008); mental health (Griffiths, 1997; Kates and Ackerman 2002); long-term care (Cott, 1997) and palliative care (Street and Blackford, 2001). From the literature on interprofessional working, it can be concluded that all of the studies and research related to interprofessional working are carried out in the developed countries and in the developed health economies. There has been hardly any research carried out in

developing countries on this topic. Health care professionals from Nepalese hospitals clearly expressed their perceptions of interprofessional working practices. This research gives an insight of interprofessional working practices in the context of Nepalese hospitals. Therefore, this empirical research on interprofessional working in Nepal would certainly contribute to the existing body of knowledge and has contributed theoretically and empirically in the field of interprofessional working and team collaboration. The findings of this research are in line with the literature in this field despite the fact that Nepalese health care professionals lack training and development for interprofessional working; and the absence of formal strategies, protocols and guidance for interprofessional working at local and national level.

The main focus of this study was on three groups of health care professionals – nursing, medical and allied health professionals. This study assesses their perceptions of interprofessional working and collaborative practices on health care delivery. This study concludes that health care professionals understood the importance of interprofessional working and they perceived various benefits of interworking working to service users, health care professionals and health care systems and organisations. Moreover, health care professionals in Nepalese hospitals realised that the support from health care organisations plays a vital role for successful interprofessional working and they highlighted the need of appropriate organisational structures for interprofessional working. Another important aspect of this study is to examine interprofessional relationships, professional identities, autonomy, boundaries, culture, communication and interaction among health care professionals in Nepalese hospitals. Health care professionals perceived an unequal engagement and involvement of health care professionals for making clinical decisions.

The importance of involvement and engagement of service users in interprofessional care teams is one of the interesting findings of this empirical research. All health care professionals welcomed an active involvement and engagement of service users in interprofessional care. This research suggests that service users should be considered as a part of interprofessional care teams. This research confirms that health care professionals value service users' involvement and engagement for the delivery of health services.

This study identifies gaps in important areas of interprofessional working in hospitals in Nepal. Firstly, the health care professionals felt the need for hospital protocols and guidance supported by national policies on interprofessional working as they have pointed out that there are no policies and guidance to standardise and support the interprofessional team collaborative practices hospitals in Nepal. Secondly, the health care professionals mentioned that there was no provision of training and education to enhance their skills, competencies and capabilities required for interprofessional working between health care professionals in Nepal. According to the health care professionals, university and college curriculum do not cover these contents and the skills are not taught at the universities and colleges in Nepal. Therefore, it is time to introduce such a curriculum and programme at medical colleges, universities and hospitals in Nepal so that modern health care workforce meet the international standards required in the twenty-first century. Thirdly, this study reveals issues related to professional autonomy, identity, boundaries, clinical leadership, organisational support, involvement of service users and communication as discussed above in Chapter 6. This has a major impact on the way health care professionals work together in a team as all health care professionals need to trust and support each other, they need respect and equitable participation to achieve desired clinical outcomes and to deliver modern health services.

This empirical research examines power perspectives of the theory of professions in relation to interprofessional working in Nepalese hospitals. This study confirms that the power perspective of the theory of professions is equally applicable in the context of Nepalese health service delivery. This research concludes that dominance of medical professionals exists in Nepalese hospitals and medical professionals gained power through education, regulations, knowledge and expertise. Moreover, health care professionals felt that they influenced clinical decision making and delivery of health care. There was an agreement that medical professions lead the interprofessional care team and took ownership of decisions. Participants felt boundaries of health care professionals are changing; nursing and allied health professionals are more recognised and valued.

In summary, it can be concluded that this research has contributed empirically and theoretically to the main literature and contributed to knowledge. This study gives an insight about interprofessional working in Nepalese hospitals and adds value by assessing interprofessional working practices in a developing country. It also helps to develop appropriate strategies and policies; and develop a sound framework for interprofessional working in Nepalese hospitals. Moreover, the finding of this research gives baseline information for comparison for further research in this area, primarily in developing countries. This research has also identified areas of further research in this field as described in Section 8.6 in this chapter. It is believed that the recommendations made by this research would help to improve interprofessional working practices in Nepalese hospitals.

8.5 Limitations of the Study

The findings of the research highlight important issues of interprofessional working between medical, nursing and allied health professionals in the Nepalese health care

context. Interprofessional refers to working between various professional groups such as medicine, nursing, therapists, bio-medical scientists, radiographers, pharmacists, various technicians, education, social work, police, management and administration. This study does not include management or administration and non-care oriented specialists such as information technology, finance, social work, education and so on. Further research can be carried out to assess the impact of interprofessional working in wider groups of professions working in the hospital.

This study was carried out in three specialist secondary care hospitals in Kathmandu, Nepal. The findings of the research cannot be generalised throughout the whole health sector in Nepal. For example, primary care organisations may have a separate mechanism of interprofessional care practice and further research could include these organisations. The obvious limitation of this study was the lack of comparative clinical outcome data among various teams or departments. Therefore, there was no comparison between various teams in this study. The hospitals under study did not have a system or process to measure the clinical outcomes of interprofessional working. Therefore, the absence of the data and figures made it impossible to cross-verify the perceptions of health care professionals with the clinical outcomes of interprofessional working.

Interprofessional working is a complex issue and it can be viewed and understood differently by different stakeholders (Odegard and Strype, 2009). Many research scholars and authors confirm service users as important players of delivery of health care and interprofessional working. This research does not include service users as a subject of the study. Therefore, it cannot be confirmed what service users perceive about the outcomes of interprofessional working between health care professionals. Research on interprofessional working, patients' roles, their involvement and perceptions could be interesting and useful.

Interprofessional working practices can be viewed in two ways, internal and external (Willumsen, 2006). Internal collaboration means collaboration between the health care professionals within the same hospital and external collaboration is about collaboration with professionals form other hospitals (Odegard and Strype, 2009). This research assesses interprofessional working within the same organisation, which means it focuses on the internal collaboration and excludes the wide scope of research on external collaboration and interprofessional working between various groups of health care professionals.

The knowledge, skills and capabilities required for effective interprofessional working; and principles of interprofessional working are equally relevant and important to any level, field or disciplines in health care where different health care professionals are required to work together. However, this study is focused on secondary and tertiary care health service providers in Kathmandu, the capital city of Nepal.

8.6 Suggestions for Further Research

Interprofessional working is a broad subject with many facets. As discussed in the earlier chapters, this research examines how health care professionals collaborate and assesses their perceptions of interprofessional working on health care delivery in Nepalese hospitals. There are many other areas of interprofessional working, which can be very useful and interesting for further research. The following suggestions are made for the further research in the field of interprofessional working in health care.

This research does not include administrative or management staff and other support workers. They are an important part of the health care delivery system, even though they are not directly involved in patient care. Moreover, this research does not include health care and hospital managers. They are key players of the health care delivery system, who

develop hospital strategies, policies and guidance for the operation and management of clinical services and to prioritise resources. They work closely with health care professionals and influence the delivery of health services. In this context, research including all staff (clinical, non-clinical, managerial, administrative and support staff) can give better clues in order to examine perceptions of health services staff on interprofessional working. Moreover, future research on interprofessional working could include service users, their roles and involvement; and it could give a useful insight on this topic.

This research does not include primary care and community services. Health services cannot be viewed in isolation of one particular service and it has to be viewed as a holistic approach of primary, secondary and tertiary care for the wellbeing of service users and effective delivery of patient care. Therefore, interprofessional working at all levels of health services such as primary and community care, secondary care and tertiary care would be useful and interesting.

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Appendices

Appendix 1: Letter to Nepalese Hospitals

Date:……..

Dear .....,

Mr Bachchu Kailash Kaini is carrying out a research on 'Interprofessional working in hospitals: the case Nepal' as a part of his PhD research at this University.

The main aim of the study is to examine how health care professionals collaborate and to assess their perceptions of interprofessional collaboration on health care delivery. Please see the attached details of the research design.

A team of health care professionals will be selected to take part in the research. Health care professionals of the team will be requested for an interview, which may last approximately 45 minutes. The questions are designed to draw upon their experiences and perceptions of working with other health care professionals.

I would like to assure you that participants' responses will be anonymous and will be treated as confidential. No names will be used and no individual will be identified. All respondents, teams and the hospital will be offered the opportunity to view the completed work.

I believe this research will be very useful to assess interprofessional working in the Nepalese hospitals and to improve interprofessional teams. I kindly request you to grant permission to carry out this research in your esteemed hospital.

I look forward to hearing your response on this matter. If you have any questions or would like more information please do not hesitate to contact me.

Many thanks.

Yours sincerely,

Dr Ulke Veersma

Senior Lecturer HRM Employee Dev/International HRM

Business School

Appendix 2: Letter to Nepal Health Research Council for Approval

Date:…….

Member Secretary
Nepal Health Research Council
Ramshahpath
Kathmandu, Nepal

Subject: Interprofessional Working in Hospitals: The Case of Nepal

Dear Sir,

Mr Bachchu Kailash Kaini is carrying out a research on 'Interprofessional working in hospitals: the case of Nepal' as a part of his PhD research at this University.

The main aim of the study is to examine how health care professionals collaborate and to assess their perceptions of interprofessional collaboration on health care delivery.

This research has been approved by the Research Committee and Research Ethics Committee at University of Greenwich. As an academic supervisor I am supervising and monitoring the research. I fully support Mr Kaini to carry out the research in Nepalese hospitals.

I believe this research will be very useful to assess interprofessional working in Nepalese hospitals and to improve interprofessional teams. I kindly request you to grant ethical approval to carry out this research in Nepalese hospital.

I look forward to hearing your response on this matter. If you have any questions or would like more information please do not hesitate to contact me.

Many thanks.

Yours sincerely,

Dr Ulke Veersma

Senior Lecturer HRM Employee Dev/International HRM

Appendix 4: Information Sheet and Letter to Interviewees

Date: …….

…….

Dear ……...,

I am carrying out a research on 'Interprofessional working in hospitals: the case of Nepal' as a part of my PhD research at the University of Greenwich.

The main aim of the study is to investigate the interaction between and within various professions in hospitals, especially working in interprofessional care teams, and perceptions and practices of their members. I would like to invite you for an interview in order to collect data for the research. Your participation in this research is very important. Your response will be anonymous and will be treated as confidential. No names will be used and no individual will be identified.

I would like to record an interview, lasting approximately 45 minutes, during which I will ask you to describe your experience of working in an interprofessional care team. Following the interview, I will transcribe the dialogue, and make use of the text in my thesis. The interview will be transcribed verbatim, but identifying characteristics will be edited to preserve confidentiality. I will be undertaking the transcription, and tapes will be wiped once the transcript is complete. Texts will be identified by code numbers, no names will appear on interview transcripts, and pseudonyms will be used within the thesis.

I will provide participants with a copy of their transcript. If for any reason and at any time you wish to withdraw from the research, I will delete your interview from the data set and remove all references from the text. If you wish to amend the transcript, either for purposes of clarification, or to remove sensitive material, I will make the amendments, and delete the relevant passages from the data set and the text. You are free to withdraw from the research at any time.

I would like to thank you for taking part in this research. If you have any questions or would like more information please do not hesitate to contact me.

Many thanks.
With best regards,
Bachchu Kailash Kaini
Kb29@gre.ac.uk

Appendix 5: Participant Consent Form for Interview

Research Title: Interprofessional Working in Hospitals: The Case of Nepal

Researcher: Bachchu Kailash Kaini

- I have read the information sheet about this study
- I have had an opportunity to ask questions and discuss this study
- I have received satisfactory answers to all my questions
- I have received enough information about this study
- I am assured that confidentiality is guaranteed
- I understand that I am free to withdraw from this study:
  - At any time (until such date as this will no longer be possible, which I have been told)
  - Without giving a reason for withdrawing
  - (If I am / the participant is, or intends to become, a student at the University of Greenwich) without affecting my / the participant's future with the University
  - Without affecting any medical or nursing care I may be receiving.
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking here.
- I agree to take part in this study ☐

In order to send transcripts, and/or to follow up any issues I need to be able to get in touch with you, please indicate:

a) If you are willing to allow me to make further contact if necessary: Yes / No

b) Your contact details:

Email: …….

Telephone: …….

Address: …….

Please sign below, to indicate your willingness to participate in the second round of data collection (interview) for this study.		
Name:	Signature:	Date:
Name in block letters (researcher): Bachchu Kailash Kaini		
Signature of researcher:		Date
This research project is supervised by: Dr Ulke Veersma, Senior Lecturer, and Prof Linda Burke, Pro-Vice Chancellor, University of Greenwich. Please see below for the address. Email: u.veersma@gre.ac.uk. Or Linda.Burke@gre.ac.uk		

Researcher's contact details:

Bachchu Kailash Kaini

PhD Student

Business School

University of Greenwich

Old Royal Naval College, Park Row

Greenwich, London SE10 9LS

Phone: 00 44 208 331 9003, Email: kb29@gre.ac.uk

Appendix 6: Semi-Structured Research Interview Schedule

Interprofessional Working in Hospitals: The Case of Nepal

Research Interview Schedule

Type of hospital: Public □ Private □ NGO/Voluntary □

Department/Specialty: .....

Current job title: ……..

Your professional group: Medical □ Nursing □ Allied health professionals (AHPs) □

Education: Undergraduate □ Postgraduate □ Vocational □

Gender: Male □ Female □

Section 1: General view on IPC and healthcare

1. **Important factor in improving patient care**: What do you think is the most important factor in improving the patient care? How important is, compared to other organisational factors, good interprofessional care for the improvement of health care?
2. **Importance of IPW**: Could you please describe the importance of interprofessional working (IPW) for health care professionals? How does interprofessional working help to improve the outcome of patient care? Can you please describe the factors that support IPW?

Section 2: Different roles at the workplace and teamwork

3. **Experience**: Please describe me your experience of working in interprofessional care team/s. (learning as a student, day-to-day job, working with other professions, on-the-job learning, etc.).
4. **Roles and responsibilities**: Define your professional roles and responsibilities in interprofessional care team (What do you do? Who assigns your roles and responsibilities? How do you define your role as a team member? Overlapping roles and responsibilities between various team members, etc.). Do you share responsibilities for team's success and failure?
5. **Skills and competence**: Where do you learn your skills for IPW? Are there any formal or informal courses/training to enhance IPW? What are the skills and competence required for interprofessional collaboration between health care

professionals? Do you think you receive adequate interprofessional care training to do your job well? Do you think you are competent and capable to work with other health care professionals?

6. **Communication and interaction**: Do you think your department/hospital has a good mechanism of communication between team members? Do you think your team members communicate effectively? What are the means of communication in IPCT? Do you have formal policies and protocols for IPW?
7. **Leadership**: Who leads the team? How does your team leader support and encourage you in the delivery of health care? Do you think that your team leader is competent and empowered? Attitudes of team leader, leadership styles, shared vs. individual leadership etc.
8. **Decision making**: How do you, as a health care professional, make decisions? How do you involve patient in the decision making process? Do you have influence on team decision making? Ownership of decisions, consensus for patient treatment or care etc.

Section 3: Professional identity, autonomy, power and decision making:

9. **Professional identity & autonomy:** Please tell me about your professional identity in the hospital, the department and the team. (Your identity and role in the team, professional status, regard, esteem; conduct, what other say about you? What do they think about you?). Please tell me your experience of professional autonomy in interprofessional care team (degree of control of your profession, independent judgement of your work, what do you think about autonomy in your profession? Do you think that your autonomy is respected? How do you see yourself and others as an independent practitioner?)
10. **Professional boundaries:** What are the professional boundaries in interprofessional collaboration between health care professionals? What are the impact of overlapping and blurring professional boundaries?
11. **Professional power**: Please tell me about professional power in your team. (Sources of power, professional dominance, power sharing, structure, hierarchy, authority, role of hierarchy, knowledge/skills in clinical assessment, superiority etc.)

12. **Professional culture**: Please tell me about professional culture among HCPs in your team and hospital? (Values, attitudes and beliefs towards IPC, Is there any different culture between different professions? Willingness to contribute and shape change etc.
13. **Professional ethics**: What do you think about professional ethics in health care team? (Standards of behaviour and practice, patient focused orientation of care, code of conduct, professional norms at work, ethical practices, understanding of own and other health professions ethics, etc.).
14. Are there examples of **conflicts** between opposing (views on) ethical standards and until what extent are they related with various professional backgrounds?

Section 4: Triggers of, and barriers for interprofessional care

15. **Barriers for IPW**: What are the barriers of working in an interprofessional care team? Could you please describe the conflicts and tensions between health care professionals while working as a member of interprofessional care team?
16. **Suggestions**: Can you please offer any suggestions in order to improve relationships between various health care professionals and improving interprofessional care practice? What are in your view the main triggers?

Appendix 7: Interview Schedule Translated in Nepali Language

नेपाली अस्पातलहरुमा अन्तर्-पेसागत सहकार्य

(Interprofessional Working in Nepalese Hospitals)

साक्षात्कार सुची

भाग १: स्वास्थ्य सेवा र अन्तर्-पेसागत सहकार्यको बारेमा सामान्य बिचार

१) बिरामीको स्वास्थ्य सेवा सुधार गर्नको लागि सबैभन्दा महत्वपूर्ण तत्व के के हुन? अरु संस्थागत तत्वको तुलनामा अन्तर्-पेसागत सहकार्यको भूमिका बिरामीको अवस्था सुधारको लागि कती महत्वपूर्ण हुन्छ?

२) स्वास्थ्यकर्मिहरुको लागि अन्तर्-पेसागत सहकार्य कत्तिको महत्वपूर्ण हुन्छ? अन्तर्-पेसागत सहकार्यले कसरी बिरामीको अवस्था तथा नतिजा सुधार गर्नको लागि कसरी मद्धत गर्छ? कुन कुन तत्वले अन्तर्-पेसागत सहकार्यलाई सहयोग गर्छ?

भाग २: समुह तथा काममा खेल्ने बिभिन्न भूमिका

३) तपाईंको पेसागत सहकार्यको अनुभव बताई दिनु हुन्छ कि?

४) पेसागत सहकार्यलाईमा तपाईंको भूमिका र जवाफदेही के के हुन? कस्ले तपाईंको भूमिका र जवाफदेहिता तोक्छ? तपाईंको भूमिका एउटा समुहको सदस्यको रुपमा के हुन्छ? कुनै कुनै भूमिका एक आपसमा खट्टिएको हुन्छन कि? तपाईंहरु एक आपसमा जिम्मेवारीहरु कसरी बाँडफाँड गर्नु हुन्छ?

५) तपाईंले अन्तर्-पेसागत सहकार्यको दक्षता कहाँ सिक्नु भयो? तपाईंको अस्पातलमा अन्तर्-पेसागत सहकार्य को सिप बढाउनको लागि कुनै तालिम हुन्छन कि? अन्तर्-पेसागत सहकार्यको लागि कुन कुन सिप र दक्षताको आवश्यकता पर्छ? तपाईंले अन्तर्-पेसागत सहकार्यको लागि आबस्यक पर्ने सबै तालिम लिनु भएको छ? तपाईं आफुलाई अन्तर्-पेसागत सहकार्यको लागि योग्य ठान्नु हुन्छ?

६) तपाईंको बिभाग वा अस्पातलमा संचारको लागि आवश्यक पर्ने सबै ब्यबस्थाहरु छन्? तपाईंको विचारमा तपाईंको समुहको सबै सदस्यहरु एक आपसमा राम्रोसँग संचार आदनप्रदान गर्न सक्छन? अन्तर्-पेसागत सहकार्यमा संचारको लागि के के साधन को प्रयोग हुन्छ? अन्तर्-पेसागत सहकार्यको लागि आवश्यक पर्ने सबै निती तथा नियमहरु छन् हस्तो लाग्छ तपाईंको अस्पातलमा?

७) तपाईंको समुहको नेता को हो? तपाईंको समुहको नेताले तपाईंलाई कसरी हौसला र सहयोग गर्नु हुन्छ? के तपाईंको समुहको नेता सक्षम र सशक्त हुनु हुन्छ जस्तो लाग्छ? तपाईंको समहुको नेताको रवैया, शैली र चालचलन कस्तो लाग्छ? तपाईंको समुहको नेताले सामुहिक वा ब्यक्तिगत कस्तो किमिमको नेतृत्व गर्नु हुन्छ?

८) एउटा स्वास्थ्यकर्मिको नाताले बीरामीको लागि कसरी निर्णय लिनु हुन्छ? निर्णय गर्ने प्रकृयामा बिरामीलाई पनि सामेल गर्नु हुन्छ? तपाईंले समुहको निर्णयमा प्रभाब पार्न सक्नु हुन्छ? तपाईंहरुले गर्ने निर्णयको जिम्मेवारी कस्ले लिन्छ? बीरामीको उपचारको लागि कसरी सहमति मा पुग्नु हुन्छ?

भाग ३: पेशागत शक्ती, पहिचान र निर्णय गर्ने तरिका

९) तपाईंको पेशागत पहिचान को बारेमा केही बताई दिनु हुन्छ कि? अरु स्वास्थ्यकर्मीले तपाईंलाई कसरी हेर्छन? तपाईंको बारेमा के सोच्छन? पेशागत स्वयत्तताको बारेमा तपाईंको अनुभव कस्तो छ? तपाईंको पेशा स्वयत्त छ? तपाईंको स्वयत्त अरु स्वास्थ्यकर्मीले कदर गर्नु हुन्छ? तपाईं आफु वा अरु कुनै स्वास्थ्यकर्मीलाई कसरी स्वन्तन्त्र काम गर्ने स्वास्थ्यकर्मीको रुपमा हेर्नु हुन्छ?

१०) अन्तर्- पेसागत सहकार्यमा हरेक पेशा का के के सीमा हुन सक्छन? एक आपसमा मिल्ने र खट्टिने पेशागत सीमाको असरहरु के के हुन्छन?

११) तपाईंको समुहमा पेशागत शक्ती को बारेमा केही बताई दिनु हुन्छ कि? पेशा गत शक्तीको श्रोतहरु के के हुन? कुन पेशाले धेरै प्रभाव पार्छ? वा कुन पेशा सबै भन्दा हावी छ?

१२) तपाईंको समुहमा पेशागत संस्कृतिको बारेमा केही बताई दिनु हुन्छ कि? तपाईंलाई बिभिन्न पेशाको आ- आफ्नै संस्कृति र काम गर्ने तरिका हुन्छ जस्तो लाग्छ? तपाईं कुनै काम गर्ने तरिका वा संस्कृति परिवर्तन गर्नु पर्ने भएमा तयार हुनु हुन्छ?

१४) के तपाईंको अरु कुनै पेशाकर्मीसँग एक अर्को बिचमा वा आपसमा द्वन्द हुने वा द्वन्द भएको कुनै सम्झना छ? वा कुनै उदाहरण दिन सक्नु हुन्छ? त्यस्ता द्वन्द हरु एक आपसमा कसरी सम्बन्धित हुन्छन?

भाग ४: अन्तर्- पेसागत सहकार्यको चुनौती तथा समस्या समाधान गर्नको लागि सुझाव

१५) अन्तर्- पेसागत सहकार्यको लागि समुहमा काम गर्दा के के बाधा अडचनहरु आउंछन? समुहमा अरु कुनै पेशा कर्मीसँग काम गर्दा एक आपसमा आउने तनाव वा द्वन्दको बारेमा तपाईंको अनुभव के छ?

१६) बिभिन्न स्वास्थ्यकर्मी को सम्बन्ध सुधार गर्नको लागि र अन्तर्- पेसागत सहकार्य सुमधुर गरी बिरामीको स्वास्थ्यमा आवश्यक सुधार गर्नको लागि तपाईंको के के सुझाबहरु छन? स्वास्थ्यकर्मीको सम्बन्ध सुधारको लागि प्रमुख तत्वहरु के के हुन जस्तो लाग्छ?

तपाईंको सुझाब र सहयोगको लागि धेरै धेरै धन्यवाद ।

Appendix 8: Protocol for Case Study

Interprofessional Working in Hospitals: The Case of Nepal

1. Introduction:

This protocol has been developed to carry out the case study research which contains the procedures to collect data, research instrument and general rules to be followed in using this protocol during the research. The main objectives of the protocol are to facilitate the case study research and to increase the reliability of case study.

1.1 Overall aim: The main aim of the study is to examine how health care professionals collaborate and to assess their perceptions of interprofessional collaboration on health care delivery.

1.2 Objectives:

- To identify and analyse various factors that support and hinder interprofessional collaboration in Nepalese hospitals
- To examine understanding of, and perceptions of interprofessional collaboration among health care professionals
- To assess perceptions of interprofessional collaboration on health care delivery in Nepal
- To examine power model of theory of professions in relation to interprofessional working

1.3 Research questions:

- How do various health care professionals interact and collaborate in hospitals?
- Which factors support and hinder, in what way, collaboration between various professionals in teams providing health care and support?
- How do health care professionals perceive the impact of interprofessional collaboration within teams on the delivery of health care?
- How does the power model of theory of professions relate to interprofessional working?

2. Data Collection Procedures:

2.1 Site and Contact Person:

i. Shahid Gangalal National Heart Centre, Bansbari, Kathmandu

Contact Person: Dr Man Bahadur KC, Executive Director and Dipendra Khadka, Deputy Head of Administration

ii. Medicare Hospital, Chabahil, Ring Road Kathmandu

Contact Person: Dr Abani Bhusan Upadhyaya, Chairman and Divakar Khadka, Administrator

iii. Tilganga Eye Hospital, Tilganga, Gaushala, Kathmandu

Contact Person: Dr Rita Thapa, Chief Operating Officer and Bhagirath Baniya, Administrator

2.2 Data Collection Plan:

i. Participants: Health Care Professionals (Medical, Nursing and Allied Health Professionals)

ii. Date: June - July 2013. All interviews will be conducted at the hospital at the time and date of their choice. The duration of each interview varied.

iii. All interviews were recorded in a digital format with the informed and written consent of the participants.

2.3 Expected Preparation Prior to Site Visit:

i. Essential equipment and documents: Digital Recorder, invitation letter, consent form, interview schedule, approval letter from the hospital, note book, pen and diary.

3. Outlines, Skills and Criteria for the Case Study:

3.1 **Case Study Sites and Participants**: Three cases and three sites as stated in section 2.1. A team in each hospital and all health care professionals working in the team.

3.2: **Sources of Data**: Interviews and focus groups

3.3 **Other Data/Information**: Hospital policies, guidelines and standard operating procedures for interprofessional working.

3.4 **Skills for the Case Study:**

- Good knowledge of the health care set up, team practices/dynamics and health care professionals (phenomenon)
- Preparation for unexpected issues in data collection
- Preparation of good questions and ability to ask questions
- A good communicator and listener
- Flexible approach and enthusiastic

3.5 **Criteria for the Case Study**

- Research aims, objectives and questions followed from the beginning of the study
- Data is collected in a planned and consistent manner
- Inferences are made from the data to answer the research question
- Explores a phenomenon, or produces an explanation, description, or causal analysis of it
- Threats to validity are addressed in a systematic way

(Perry et al 2005):

3.6 **Semi Structured Interview Questions:** Attached **(**Please see Appendix 6 and 7).

Appendix 9: Sample Interview Transcript

Section 1: General view on interprofessional care and healthcare

1. **Important factor in improving patient care**: *What do you think is the most important factor in improving the patient care?*

   In my view, nurse to patient ratio is a vital factor. The level of manpower contributes the most. Even within the manpower, competent manpower is essential. Availability of updated, maintained and sufficient equipment in the time of need also plays an important factor. It is countable and visible. Organisation motivates from behind the scene. If there is no team collaboration, until and unless the doctors prescribe, nurses do not do anything and it can also take the life of the patient. If there is good team collaboration, when patients come they usually get care on time.

   How important is, compared to other organisational factors, good inter professional care for the improvement of health care?

   As I mentioned earlier, there are various factors and individuals. The importance of each factor can be based on the need and circumstances that the service is offered to patients. Sometimes teamwork is important, at other times equipment can be the important factor for improving the health condition of patients.

2. **Importance of interprofessional working (IPW)**: *Could you please describe the importance of interprofessional working for health care professionals?*

   Health care is mainly teamwork. Knowingly or unknowingly we practice interprofessional working. I personally work with so many professionals in everyday life and it is for the benefits of each other. That's how interprofessional collaboration comes in the scene.

   How does interprofessional team collaboration help to improve the outcome of patient care?

   I will give you an example. There is one patient with multiple problems on the medical ward. He came here for one cardiac problem. Apart from daily nursing care, he needs service and counselling from physiotherapist, nutritionist, doctors, pharmacists and the list goes on. Without working together in interprofessional team, his health conditions cannot be improved. Therefore, teamwork helps to improve outcome of patients.

Can you please describe the factors that support IPW?

Information is the most vital factor to maintaining good interprofessional working. Everyone must realise that while communicating, no one would be dominated. Secondly, there should be a protocol; I mean a protocol of interprofessional care. We should think about extra things such as standing order or protocols for interprofessional working. In the time of crisis, certain works must be done by the people from another profession to save a patient's life. There must be written protocol. In nursing profession, it is called standing order. Interpersonal communication must be done and one professional should respect other fellow professionals. Thirdly, we should organise trainings from time to time. Finally, communication is very important and we should understand the barriers of the communication. How doctors communicate with nurses and how the nurses respond to that, there should be training for all professionals.

Section 2: Different roles at the workplace and teamwork

3. **Experience**: *Please describe me your experience of working in interprofessional care team/s.*

   I have worked as a nurse for more than 25 years and I have faced different experiences. I am happy that I have come across with many good experiences. In few occasions, I experienced some challenges.

   What are those challenges? Can you please further explore?

   Communicating with the same level of persons is not as difficult as communicating with management and doctors. I have a really bitter experience whilst communicating with the management team and the doctors. Management to technical line and doctor to nurse communication is often dominating. Humiliation often decreases the communication effectiveness.

   What about other training or support to come over those challenges?

   Yes, in my 25 year long career, I attended a 4 day communication training organised by the nursing association. Apart from that, there is no training organised on this topic from the organisation where I am working

4. **Roles and responsibilities**: *Can you please define your professional roles and responsibilities in interprofessional care team?*

As a senior nursing supervisor, I have to deal with nurses for making nursing services efficient and effective. If there is any problem, they come to me and while solving the problem, I have to go up to the matron. I have to work as a facilitator. I also work as a co-ordinator, mentor and supervisor.

Do you work with medical and other professionals as well?

Yes, sometimes I directly go to medical unit chief. It is not written that I have to see him, but there is a practice to consult with him if there are any issues. I work with other professions but frequency of meeting and intensity of the work is not the same as medical professions. We have management team meetings and I do interact with all professions at the meetings.

Do you think that overlapping happens when you work with different professions?

Yes, overlapping happens and it is regarded as human error. And we think that has given us knowledge. For example I have to watch 6 wards and sometimes I go there to direct them. But at the same time there is the matron doing the same thing. Even doctors are also directing the same thing. And what we realise is it could be directed by only one person. I can find some good and some bad aspects.

Do you think your roles and responsibilities are defined?

Yes, in terms of nursing roles and responsibilities, they are defined in the job description. But whilst working in team collaboration, there are no written or definite roles and responsibilities. We should work using our own wisdom and experience.

Do you share responsibilities for team's success and failure?

I think it depends on the team and individual. Some would like to share and few do not want to share anything.

5. **Skills and competence**: *Where do you learn your skills for IPW?*

Theoretically we learnt it in college when we were taught communication module. From intermediate to MPhil, we have to study communication in the chapter of management. It often makes it easier. We learn many things that are needed for good team management. There is no learning about it at work.

Are there any formal or informal courses/training to enhance IPW?

Do you mean at the workplace or university?

At both place. Are there any training?

No, as far as I know. There is no particular module in the university courses or no training for staff in this hospital. Therefore, it is all learning by experience at workplace .

What are the skills and competence required for interprofessional collaboration between health care professionals?

The most important skill is communication. Then I can think of co-ordinating and facilitating.

Do you think you receive adequate interprofessional care training to do your job well?

No, I have not received any training on this subject.

Do you think you are competent and capable to work with other health care professionals?

If I say I am completely competent, it is a kind of mental disorder. It is personality disorder. But I have the feeling that I can maintain the team collaboration. I really feel competitive and comfortable whilst communicating with other people in other professions because in other professions we cannot find good communication skills.

6. **Communication and interaction**: *Do you think your department/hospital has a good mechanism of communication between team members?*

   There is no fixed mechanism for communication.

   Do you think your team members communicate effectively?

   Not all the members have the skill and sometimes we have to face problems.

   What are the means of communication in IPW?

   We mainly do verbal communication, like face to face meeting or briefing. We have morning conference for case discussion and team meetings periodically.

   Do you have formal policies and protocols for IPW?

   There are no policies or protocols for interprofessional working.

7. **Leadership**: *Who leads the team?*

   In my personal experience medical doctors lead the team and we are seen as supportive team to them.

How does your team leader support and encourage you in the delivery of health care?

Team leaders' support varies time to time but it is fine. In other words, they are good. They support us.

Do you think that your team leader is competent and empowered?

Yes, they are competent but still there are things to improve. Sometimes there is a problem in attitude. Most of the times I feel that the leaders are autocratic. Some of them follow participatory approach. The leaders from the upper level or seniors want to work individually and some of them want to share. Most of the senior leaders work individually, and juniors want to work in teams.

8. **Decision making**: *How do you, as a health care professional, make decisions?*

   Most of the decisions are doctor dominated. Some of the decisions are made by management too. But there is no participatory decision making. There is a daily morning conference; patient related team discussion mostly occurs here. Doctor visits happen in a daily basis.

   How do you involve patient in the decision making process?

   In some of the cases, patients are involved. In some of the cases it is related to finance, therefore we have to involve patients and we have to talk to them for affordability rather than discussing health issues.

   Do you have influence on team decision making?

   I would say partially, I can sometimes influence the decision making. For example if a patient is facing financial problem and if I think the patient is genuine, he/she is really poor then I can influence the decision and continue their care. In other cases, though theoretically the decision is made jointly but in practical ownership is constructed fully by doctors and our influence is very little.

Section 3: Professional identity, power and decision making:

9. **Professional identity & autonomy:** *Can you please tell me about your professional identity in the hospital, the department and the team.*

   Now, I find my profession is recognised very well. I do not find my profession equivalent to other professions like medicine. When I started nursing job 25 years ago,

it was not respected job and there was very little recognition. Nursing profession now is considered a very attractive to many young people.

Please tell me your experience of professional autonomy in interprofessional care team.

Regarding autonomy I am not satisfied. We are on the way. We are not independent. While working in the ward we find that the patient needs care but unless and until the doctor prescribes, we cannot do anything.

Do you think that your autonomy is respected?

Do you mean respect from nursing colleagues or other professionals?

I meant from all health care professionals in the hospital. What do you think?

No.

Why do you think your autonomy is not respected?

I think it's simply because people's attitude and the way they are trained and work in the team.

How do you see yourself and others as an independent practitioner?

No, I do not consider myself as an independent practitioner. We dependent heavily on medical professions and other senior management.

10. **Professional boundaries:** *What are the professional boundaries in interprofessional collaboration between health care professionals?*

As a nurse we have to face more problems. It has many causes, because it is the female profession, doctor dominated profession and it is regarded as an assistant profession. We feel dominated from other professions too. I do not find so much harassment but respecting the boundaries of the profession is very less. I think professional interference, overstepping, and encroachment are some of the boundaries.

What are the impact of overlapping and blurring professional boundaries?

It may cause delay in patient's care. Staff's de-motivation can cause interference in the quality of care. After all it causes problems financially to the organisation and the patient.

11. **Professional power**: *Please tell me about professional power in your team.*

It may be professional hierarchy, education, authority, personal impact and decision making power, these are the sources of professional power. Health care is mainly doctor dominated profession and there is less power sharing among health care professionals and I feel there is more professional dominance.

Why do you think there is more professional domination?

Medical professionals always think that they have professional supremacy. The reason is that they have the title 'doctor', the way our society give them the highest level of recognition and respect, the medical degree they hold and the professional and social networking they have compared to nursing and allied health professions. Some medical doctors do not talk to us every day, sometimes we think they are rude and they underestimate our work, as a result we felt humiliated and this would impact the patient care.

12. **Professional culture**: *Please tell me about professional culture among health care professionals in your team and hospital? Like values, attitudes and beliefs towards interprofessional care, Is there any different culture between different professions?*

Professionals from different fields have different culture, value, belief and attitude towards team work. They have to work to find out what kind of roles they have to play. All health care teams are not the same. They are diverse and comprised of people of different ages, from different social and cultural background. Every team members have different background, experiences, skills and capabilities, therefore own beliefs and working ethos.

13. **Professional ethics**: *What do you think about professional ethics in health care team? like standards of behaviour and practice, patient focused orientation of care, code of conduct, professional norms at work, ethical practices, understanding of own and other health professions ethics, etc.*

We normally do not cross the boundaries, but we cannot work within the boundaries sometimes. For example, raising the voices in the favour of patients cannot be done due to external interference. Sometimes we cannot say a word, even if something is happening that is not good for the patient's situation. It is not that we always can work on the behalf of the patients. And we feel morally sad. Secondly, we have our nursing

code of practice for nursing personnel, which is universal and approved by Nepal Nursing Council. We simply follow our code of practice.

14. **Conflicts:** *Are there examples of conflicts between opposing views on ethical standards and until what extents are they related with various professional backgrounds?*

Yes, I have. There was a wound in the leg of a patient we had to send for culture. While attempting to send the culture, one doctor said it should be sent after painting with beta din, then I said no, if we paint with beta din the organism becomes inactive and the real problem does not come to the result. The doctor argued with me, and I sent the patient without paint and said that we would talk tomorrow. But, later he didn't come to talk later. It is because of professional hierarchy, he thought that I am from lower level. I was in a committee to form the law, and I raised a question "Why do doctors only get 11 grades, not a nurse? Nurse also should get 11th grade" And they said if someone says you also add 10 and I also add 10 then, both should stay in 10? Then I said you are wrong. You are 10 grades and he or she is grades 10 then both of you are same but the work you perform is different. The practice is different but the grade is the same. As someone who operates the heart cannot understand nursing care and a nurse how much she or he is trained cannot operate the heart operation. Both of them are equal by their work they perform.

Section 4: Triggers of, and barriers for interprofessional care

15. Barriers for IPW: *What are the barriers of working in an interprofessional care team?*

The first thing is professional dominance. Second thing is culture. It is the context of the country. Even in the court the things told by doctor is more reliable than said by the nurses. Thirdly, it depend which type of status the organisation gives to different professions. Fourth thing is same level of education is not recognised equally. The main communication barrier is the gap between the superiority and inferiority among different professionals. For example the communication of doctors is often superior and the communication of nurses is inferior.

Could you please describe the conflicts and tensions between health care professionals while working as a member of interprofessional care team?

We try hard not to affect the patient's care but after all it is really affected. Personal frustration and de-motivation can affect directly to the patient's care and medication error too affects it. The patient becomes the real victim because of such problems. It depends, if the work is within the boundary, difference in style does not count but when the boundary is crossed we often stop that. If it hampers the patient's care we obviously speak then. Division of roles create problems when there is a maximum flow of patients. If the situation is normal, the conflict does not happen.

16. **Suggestions**: *Can you please offer any suggestions in order to improve relationships between various health care professionals and improving interprofessional care practice?*

    Firstly, there should be a written protocol. Secondly, the organisation should give equal recognition to the equal level of education to the different professions. And the organisation should give training for the team collaboration such as communication training, management training, leadership training. These training schemes build the feeling of equality among different professions. The organisation can organise this in-house. It can be done national wide. The organisation can form a committee to develop a written protocol for interprofessional working.

Appendix 10: Example of Qualitative Results/Descriptive Analysis

Sentences / Words from Data	Categories	Themes
• Control over the authority and team • Power sharing between various professionals • Power struggle between various professionals • Doctors are seen very competent compared to other professionals • Doctors are seen as 'God' and get authority • Allied health professionals and nurses are not given the authority to make decisions • Doctors are highly respected by other professionals	Professional power	Dominance of Medical Professionals
• Feel side lined by medical professionals • Isolation due to specialised skills • No regular contact with other professional groups • We see ourselves as an auxiliary profession • Feel somewhat underutilised and undervalued	Professional isolation	
• Professional encroachment • Overstepped by medical professionals • Feel overlapping of roles • Medical professionals interfere other professionals	Interferences	
• Inadequate appreciation from each other • Being honest with oneself • Understanding and recognition of others roles and responsibilities • Hierarchical structures and lead by medical professionals	Interprofessional relationships	

Sentences / Words from Data	Categories	Themes
• Relationships set by skills set and nature of job		
• Level of intensity of interprofessional working not the same for all cases • Doctors make most of the clinical decisions • Lack of involvement in decision making • Nurses and allied health professionals feel they have least influence • Allied health professionals in the private hospital feel they are least valued • Not all involved equally in decision making process • Impartial involvement of nurses and allied health professionals in decision making	Influence of medical professionals on clinical decision making process	
• Our profession is appreciated • We have a separate identify • It is a separate profession • Nursing profession is not well recognised • I can proudly say I am a nurse • I feel proud to be an optometrist • Gained very good reputation from the public • Doctors do not respect our decision • I am well recognised by my colleagues and the public • Do not think that the nursing profession is as respected as it should be • Proud and feel happy in my profession • Doctors are respected by all people	Recognition, respect and identity	Professional Identity, Boundaries and Autonomy
• Cannot carry out medical procedures by ourselves	Professional	

Sentences / Words from Data	Categories	Themes
• Boundaries untouched by others • Overlapping often happens • Skills and competencies set professional boundaries • Regulatory body sets professional boundaries • Boundaries set by roles and job description • Grey areas between professionals • Nobody questions, and nobody interferes	Boundaries	
• My profession is autonomous • Feel confident • Medical professionals have control over other professionals • Can make clinical decisions on my own • Licensed to practice independently • There is no professional autonomy for us • Council regulate our profession	Professional Autonomy	
• Have to depend on the decision of doctors • Our profession is dependent on others • Dependent on medical professionals • Professionals are interdependent	Dependence and interdependence	
• No practice to set up rules for interprofessional working • Inconsistent approaches due to the lack of protocols • Avoids duplication by bringing clarity in roles	Organisational policies and guidance for interprofessional	Organisational Support and Structures for Interprofessional

Sentences / Words from Data	Categories	Themes
• No means to develop common platforms for shared decision making • Established process for resolving conflicts • No organisational protocols or guidance for interprofessional working	working	Working
• Team leader drives team for achieving common goals • Team leader facilitates interprofessional working • The leader is empowered • Medical professional leads the team they support us and they are competent • Interprofessional team leaders are competent and supportive	Clinical leadership	
• Interprofessional education and learning are pre-requisite for interprofessional working • Not sure about the roles, responsibilities and involvement for interprofessional working • Lack of training and education for interprofessional working • Lack of knowledge, skills and competencies for interprofessional working • Interprofessional education should be introduced at an early stage of university education • Never had a chance to learn interprofessional skills at university	Interprofessional education and training	
• Learning by doing • Lack of funding • Lack of enthusiasm from the hospital management and leaders • Senior nurses are more knowledgeable • No resources or practices to provide administrative support to interprofessional care team • Senior consultants exactly know what they are doing • Interprofessional working is an opportunity for professional development	Professional development	

Sentences / Words from Data	Categories	Themes
• No components or roles specified for interprofessional working on job description • Joint responsibilities for interprofessional working • Roles are not defined/roles are defined • Job descriptions are given/job descriptions are not given • Hospital management should define our roles and responsibilities for interprofessional working	Roles and responsibilities	
• Health care professionals have different cultures, values and beliefs • Difference in professional culture due to different in education, background and knowledge • Doctors focus on medical history and nurses focus on family history • Nurses focus on care and emotional aspect; whereas doctors focus on medical aspect	Different working styles and values	Different cultures between various professions
• Nursing is a profession dominated by female • Medical professions include male and female • Nurses as a female have different working styles • Nurses are treated differently at work place • Nurses feel suppressed than any other profession	Gender inequality	
• Nurses try to comfort the patient • Down to earth personality • Learnt sympathy and empathy • Complement to each other • Understanding problems from patients perspectives • I think patient from their perspectives	Sympathy and empathy	
• Other people do not have the same feeling as we have	Different views and	

Sentences / Words from Data	Categories	Themes
• Different views from different health care professionals – good for service users • Different views and perceptions may cause conflicts • Different professionals have different perceptions for the same thing • Different perceptions due to education system	perceptions	
• Usually do not challenge doctors • No one questions and challenge me • I expect to challenge my vies if they feel I am wrong	Challenge others' views and opinions	
• Informal communication happens all the time • Face to face meetings and verbal communication • Use of medical notes/Doctors write on medical notes • Use of memos for departmental communication • Continuous Medical Education (CME) • Vertical communication mechanism	Means of communication	Interprofessional communication and interaction
• Improvements in communication helps interprofessional working • Effective communication helps to develop great working relationships • Communication is very important for interprofessional working • Effective communication improves clinical outcomes • Team performance depends on how people communicate	Importance of communication	
• Some professionals are competent and skilled for interprofessional working	Skills and competencies for	

Sentences / Words from Data	Categories	Themes
• Members communicate effectively • No training for improving interprofessional communication • Competent for interprofessional communication • Need to organise training in communication	communication	
• Lack of time • Busy environment to focus on improving communication and interaction • Lack of policies and guidance for team communication • Many clinicians use acronyms • Use of technical terms is very common • Misunderstanding due to poor communication • Handwriting is not legible	Barriers and challenges to effective communication; and conflicts due to poor communication	
• No formal protocols for interprofessional working and communication • No mechanism for communication • Lack of proper documentation • No written protocols for the communication mechanism • There are policies for interprofessional communication • No team to team formal communication mechanism	Communication protocols	

Sentences / Words from Data	Categories	Themes
• Lack of information to patients, therefore they cannot participate in making decision • Responsible for giving full information of their diagnosis and treatment • Health care professionals get information from patients • We give patient information that is required to make a proper decision • We give patients options to decide • Patient should have a good idea of what is happening around him/her	Sharing clinical information	Involvement of service users for clinical decision making
• Should try to cure the patient as a human being • Patients are thankful for treating them nicely and giving them full information • We should respect patients' decision • The most important thing is the understanding of patient • Patients feel that they are valued, when we talk to them	Treating patient with dignity and respect	
• I do not influence patients for making decisions • Decisions for patients are made by team leaders and medical professionals • I influence the decision making process by giving them (patients) information • Patients are involved in the decision making process • Let them decide what is best for them • Some doctors make the patient involved in decision making process • We don't have role in decision making process	Influencing and involving service users on decision making	
• Without teamwork patient cannot receive authentic treatment • Patients receive quality service	Improves quality of care	Perceived benefits of interprofessional

Sentences / Words from Data	Categories	Themes
• Patients get an accurate service • Flow of proper information between professionals and it helps to improve standards		working
• Happy staff because each one learn from each other • Harmonious relations among the staff • Health care professionals get better exposure • While working alone, we might not recognise their own weaknesses • Happy patient as care is co-ordinated and integrated • Our job is to make them (patients) happy • They (patients) feel good when they see different professionals around them	Improves patient and employee satisfaction	
• Health care professionals together make a team capable of working for the welfare of the patient • Interprofessional working improves team performance • Interprofessional working improves communication • Interprofessional working improves interaction	Improves team performance, communication and interaction	
• The organisation gain goodwill • The reputation of the hospital can increase due to interprofessional working • Organisation would be benefitted through team collaboration • Patients flow increases and the organisation directly benefits • Hospital is recognised well due to care provided by interprofessional care team • Helps to improve reputation of hospital	Improves reputation	

Sentences / Words from Data	Categories	Themes
• Service delivered by different professionals • Everyone gives input • Discussed problems of the patients from various perspectives • One person or the team most of the time may not deliver the full treatment to the patient	Holistic approach of care	
• Interprofessional education not taught at the university • Lack of education and training in the country • Lack of training at the hospital • No regular CMEs from the perspectives of interprofessional working • Interprofessional working not on the curriculum	Lack of education and training	Perceived barriers of interprofessional working
• No organisational guidance or protocols for interprofessional working • No national policies for interprofessional working • Strategies for interprofessional working not developed	Lack of policies and protocols	
• Communication barrier exists here • Poor negotiation skills • Communication gaps • We do not understand each others' roles and responsibilities • Decision making not on time • Not assertive/hesitate to question or challenge • Not thinking tactically	Poor interpersonal skills	

Sentences / Words from Data	Categories	Themes
• Egoism is another obstacle • Not understanding the feeling of others is a major problem • Negative attitude • Not willingness to participate • No mutual respect between the professionals • No trust to others • Differences in cultural background	Personal factors	