Understanding the barriers to multiprofessional collaboration

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Multiprofessional collaboration is key to delivering quality patient care. Many developments in health care such as supplementary prescribing or the single assessment process rely on the premise that such collaboration already exists. This article focuses on barriers to interprofessional collaboration and explores whether ‘new ways of working’ in health care can survive in an environment with a long history of independent disciplines.

The NHS is the largest organisation in Europe. It has more than a million employees and is recognised by the World Health Organization as one of the best health services in the world (Department of Health, 2000). The Health Act 1999 imposes a duty on all NHS organisations to work in partnership (Glendinning et al, 2001). Yet recommendations from Lord Laming’s report on the Victoria Climbié Inquiry (Home Department, 2003) stress the need to improve interprofessional collaboration and there is a great deal of evidence to suggest that barriers to interprofessional working partnerships still exist.

Professional groups

Everyone in the NHS shares a common goal – the well-being and health of patients. However, this goal becomes a singular ideal within each discipline, based on the ‘cure or care’ aim of that discipline and the role of the professionals within it. It is this strong identity of professional groups that has led to rigid distinctions between them (Biggs, 1997). These distinctions are then compounded by a further combination of factors.

Communication between groups

Effective communication between professional groups is the linchpin of successful collaboration. Traditionally within the NHS this communication has relied on written formats – referral forms, feedback forms, case notes, care plans, letters, faxes and message books. However, while quality record-keeping and evidence-based policies and procedures are necessary, they can result in ‘inactive collaboration’, with each professional group having a rigid and singular input into patient care.

Purtilo and Haddad (1996) stress that verbal communication is essential to the patient and health professional relationship. Meetings can be a solution. Regular meetings of a multiprofessional team linked by a common care pathway help to enforce verbal communication and to activate that team’s collaboration. Effective integration depends on a one-door (single referral) entry into a multiprofessional team that has agreed objectives, priorities and operational procedures (Leathard, 1994; Ovretveit et al, 1997).

Professional identity and patient power

Hugman (1991) seeks to find possible solutions for the future of interprofessional collaboration based on an analysis of the idea of power within health care. Leathard, in turn, describes the rivalry between professional groups ‘as a form of social Darwinism of occupations’ (Leathard, 1994). Power struggles within society, for example the power of seniors (experienced) over juniors (inexperienced), are a barrier to interprofessional working. New developments in health care such as the generic skill-mixing approach, and a drive towards true patient-centred care – using patient power to govern the priorities of interprofessional teams – may be the way to overcome these barriers.

Differences in philosophies of care

Professional groups are known to have differing moral and ethical philosophies of care. The paternalistic approach of the cure-oriented medic versus the public health and social advocate stance of the health visitor are examples. If real power were given to patients in the form of an expert patient board responsible for the governance of an interprofessional care pathway group, then true autonomy might exist. But autonomy, as an identified ethical principle of individualised, patient-centred care, is itself challenged within health care professional groups (Woodward, 1998).

Finances and resource allocation

Professionals have markedly different pay scales according to their professional group and their role within it. Resource allocation can be a source of conflict. There is the issue of funding for staff. Seeing monies being used to employ staff from one group to provide a service normally provided by another can cause resentment. Staff shortages can also damage interaction as groups withdraw in an attempt to limit demands made upon them.

In addition there is the fear that multiprofessional collaboration is designed to reduce costs. Leathard (1994) cites McGrath’s suggestion that one of the advantages of interprofessional working is ‘more efficient use of staff’. Ovretveit et al (1997) discuss ‘ownership of resources’ – the concept of a multiprofessional team taking full responsibility for resource allocation according to patient need and its own service responsibilities.
Health care education
There is a need to challenge long-held beliefs and ideologies in health care education if we are to foster multiprofessional collaboration (McPherson et al, 2001).

Interprofessional learning
Interprofessional learning is not a new buzzword. The UK Centre for the Advancement of Interprofessional Education was founded in 1987 and focuses on how interprofessional learning fosters respect and overcomes obstacles to collaborative working. To appreciate each other’s roles we must develop trust and pride in ourselves as a unified health care provision team.

Breaking down barriers
Segregation of students based on their chosen professional pathway continues to be the norm even though much research literature challenges this practice. Segregation continues to foster ‘professional arrogance’ (Leathard, 1994) and feed the power base of professional hierarchy.

However, within postgraduate education a significant number of MSc level courses are now fully multiprofessional (Ovretveit, 1997). Health education institutes must actively develop multiprofessional preregistration programmes to encourage newly qualified professionals in multiprofessional working practices.

Change in philosophy
In current health care programmes the final hurdle for students consists of examinations and summative assessments of ability in the key skills and competencies necessary to practice. However, an extensive literature search revealed no health care programme where examination or summative assessment of the practitioner’s ability to work multiprofessionally was part of the fitness to practise rationale. Currently, the philosophy of professional education lies solely in proving your singular worth to your chosen profession.

Financial barriers
Leathard (1994) suggests that the most significant barrier to multiprofessional education is financial. Budget holders are responsible for the education funding of their own professional group. Underspend in one professional group’s budget is unlikely to be transferred into another profession’s budget irrespective of any educational need to improve patient care. In addition short courses and study days enhance multiprofessional working (Payne, 2000) and little attention has been paid to the interprofessional networking opportunities these offer.

Politics
Recent government policies for the NHS such as The New NHS: Modern, Dependable (DoH, 1997) and A First Class Service: Quality in the New NHS (DoH, 1998) cannot be delivered without multiprofessional collaboration.

Political agendas
It is not unusual for health care professionals to feel caught between government drives based on targets and patient discontent. This has a direct effect on the patient/professional relationship and alienates professional groups as they disassociate themselves from others where targets and services might be failing. Removing the NHS from political agendas and decentralising management is seen as a way to improve multiprofessional communication and therefore collaboration.

Clinical governance
If barriers created by power cultures within the NHS are to be eradicated one of the recent policies that might facilitate this is clinical governance. However, the white paper of only a year earlier A First Class Service: Quality in the New NHS (1998) actively suggests that clinical governance agendas should be driven by the medical profession (Kenny, 2002).

Budgets and audits
Professional groups often cite rationalisation, limited resources and centralised budgets as barriers to collaborative practice (Whitehead, 2001). However, Naidoo and Wills (1994) argue that financial constraints are essential to collaboration. Increased budgets alone are not sufficient. Localisation of budgets, use of resources for generic skills acquisition, auditing and improvement of multiprofessional care as part of budget allocation, and the broadening of the research arena to include all professional groups would be a step forward.

Conclusion
Modernisation of the NHS and commitment from politicians, educationalists, professionals and patients is overcoming professional barriers (Box 1). As health care professionals we have never been better placed to improve patient care through multiprofessional collaboration and working practices. Now is the time to engage all stakeholders in order to increase the momentum and to achieve the results.