

1 Interprofessional teamwork – the basics

Introduction

In this chapter we outline some of the ‘basics’ of interprofessional teamwork. In doing so, we describe a range of conceptual, political, historical and experiential elements related to the ways in which teams function. Our focus here is deliberately wide – to provide readers with an initial ‘taste’ of some of the elements that will be discussed in more depth in subsequent chapters. First, we outline a number of key dimensions of interprofessional teamwork. We then go on to explain why interprofessional teamwork is regarded as central to addressing a wide spectrum of health and social care service delivery problems. Next, we trace the emergence of interprofessional teamwork over the past 100 years, drawing on examples from a number of different countries and clinical contexts. To provide insights into contemporary teamwork issues, we go on to present direct accounts of professionals’ experiences of interprofessional teamwork in health and social care settings in a range of countries. Finally, we outline a range of implications for interprofessional teamwork.

Key dimensions of interprofessional teamwork

As noted in the Introduction, we view interprofessional teamwork as an activity which is based on a number of key dimensions. These include: clear team goals; a shared team identity; shared team commitment; role clarity; interdependence; and integration between team members. Our perspective on the important dimensions of teamworking is similar to those of our colleagues (e.g. Øvretveit, 1993; Meerabeau and Page, 1999; Onyett, 2003; Jelphe and Dickenson, 2008), which we introduce in later chapters.

Drawing on a study of primary care teams, West and Slater (1996) have usefully extended our thinking about the key dimensions of interprofessional teamwork. They found that team members viewed a number of additional elements of teamwork as being important, including:

- Democratic approaches
- Efforts to breakdown stereotypes and barriers
- Regular time to develop teamworking away from practice
- Good communication
- A single shared work location
- Mutual role understanding
- The development of joint protocols, training and work practices
- Agreed practice priorities across professional boundaries
- Regular and effective team meetings
- Team members valuing and respecting each other
- Good performance management.

Currently, however, we do not have a strong body of high quality, empirical evidence that confirms how these different elements – individually or collectively – affect interprofessional teamwork. Nevertheless, the dimensions listed above provide a useful reminder of the complex and multifaceted nature of this type of work. Accounts from the literature of the difficulties experienced in implementing interprofessional teamwork further highlight this complexity (e.g. Cott, 1998; Skjørshammer, 2001; Allen, 2002; Reeves *et al.*, 2009c). Writing from a UK perspective, the Audit Commission (1992, p. 20) has pointed out that:

Separate lines of control, different payment systems leading to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status, all play a part in limiting the potential of multiprofessional, multi-agency teamwork [...]. For those working under such circumstances efficient teamwork remains elusive.

In later chapters we investigate the complex nature of interprofessional teamwork, and explore why individuals can (and often do) experience difficulties when working as members of an interprofessional team.

Growing support for interprofessional teamwork

There has been a growing support for the use of interprofessional teamwork across health and social care settings. This support can be seen in the numerous papers and documents which argue that interprofessional teamwork is an essential ingredient for reducing duplication of effort, improving coordination, enhancing safety and, therefore, delivering high quality care (e.g. Shaw, 1970; Gregson *et al.*, 1991; Farrell *et al.*, 2001; Schmitt, 2001; Onyett, 2003). Eichhorn (1974, p. 6) offers an early argument for why interprofessional teams are needed in the delivery of care:

Health [and social care] problems have become defined in complex and multi-faceted terms. Health organisations have discovered it is necessary to have the information and skills of many disciplines in order to develop valid solutions and deliver comprehensive care to individuals and families.

This view was reiterated more recently by Firth-Cozens (1998, p. 3) who has argued that:

Teamworking is seen as a way to tackle the potential fragmentation of care; a means to widen skills; an essential part of the need to consider the complexity of modern care; and a way to generally improve quality for the patient.

Similar sentiments can be found in a range of national government policies (e.g. Department of Health, 1997; Health Council of Canada, 2009), as well as in the documents and policies of professional regulatory bodies (e.g. General Medical Council, 2001; Association of American Medical Colleges, 2009) and international agencies (e.g. World Health Organization, 1988). As the National Health Service Management Executive (1993) in the UK stated:

The best and most cost-effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service. (Paragraph 4.3)

Repeated arguments for interprofessional teamwork as well as the policy level calls for its implementation have resulted in an expansion of teamwork activities across the globe. Indeed, the range of different countries reporting interprofessional teamwork activities has rapidly increased in recent years. In addition to countries with a long track record of teamwork initiatives, such as Australia, Canada, the UK and the US, a number of other countries, including Brazil (Peres *et al.*, 2006), China (Lee, 2003), New Zealand (Pullon *et al.*, 2009), Spain (Goñi, 1999), Sweden (Kvarnström, 2008) and The Gambia (Conn *et al.*, 1996), are also reporting the use of interprofessional teamwork across a number of clinical contexts. We provide more detail on the nature of these different teamwork initiatives in the next section where we describe and discuss the emergence of interprofessional teamwork across a number of continents.

The emergence of teamwork

In this part of the chapter we offer a number of vignettes on the development of teamwork from different settings. Our aim is to illustrate how teamwork activities have evolved over time in different contexts and how it has come to the forefront of health and social care policymaking in the following six countries – Australia, Brazil, Canada, South Africa, the UK and the US.

Australia

National and state government policy directives in Australia have repeatedly noted that collaboration is a key element in improving service delivery (e.g. Australian Government, 2009). Policies such as the *Enhanced Primary Care and Medication* initiative aim to encourage the delivery of more effective care through interprofessional teamwork (McNair *et al.*, 2001). The importance of

interprofessional teams in providing primary care services is therefore increasingly recognised. However, it has been noted that progress has been restricted by traditional funding arrangements which emphasise parallel working and poor integration of professions. Efforts are currently focused on strengthening collaboration between GPs, nurses, midwives, therapists, pharmacists and dentists (Australian Government, 2008). One particular ongoing challenge is the provision of health and social care in rural areas which demands a very particular interprofessional team approach – see Box 1.1.

Box 1.1 Building teamwork in a rural Australian community.

Fuller *et al.* (2004) describe a qualitative study which involved eliciting the perspectives of 200 local stakeholders about developing a mental health plan in a remote region of South Australia. The authors found that the provision of mental healthcare in this region presented a number of difficult challenges for local health and social care practitioners. Although there was a desire by professionals to collaborate more closely with their colleagues, this appeared to be hindered by a lack of understanding of each other's roles and their respective areas of expertise as well as constraints in service delivery. Problems were particularly evident between GPs, who worked on a fee-for-service basis, and members of community mental health teams, who worked for a fixed salary. The authors suggest that agreements need to be struck between professionals about how they can work together to improve their communication and coordination activities. They also note that community mental health teams need to explore how they might work more collaboratively with other providers, such as housing, ambulance and education services, in order to provide a local integrated mental health service.

Brazil

Harzheim *et al.* (2006) note that the disease burden in Brazil results primarily from chronic diseases in adults, most notably hypertension and diabetes. In order to prevent and manage these diseases, the government has shifted its attention from acute to primary care. In 1995 it launched its *Programa Saúde da Família* (Family Health Programme) which aims to promote the use of an interprofessional team approach in primary care across Brazil. Since its inception, the number of teams has grown – collectively they cover 46% of the Brazilian population (Brazilian Government Ministry of Health, 2004). Box 1.2 provides an account of interprofessional relations in this type of team.

Canada

While Szasz (1969) outlined the need for interprofessional education, collaboration and teamwork in his paper published over 40 years ago, there was little response

Box 1.2 The Brazilian Family Health Team Programme.

Peres *et al.* (2006) describe an evaluation of the Brazilian Family Health Team programme in the state capital of Rio de Janeiro. Teams within this programme typically serve 600–1000 families and are generally composed of one family practice physician, one nurse, two auxiliary nurses and four to six community workers (team members who focus on disease prevention and health promotion). A survey of over 200 nurses and physicians' views of their approach to collaborative care was conducted following their attendance at a government-funded team training initiative. On the whole, the nurses and physicians reported that they worked in a more collaborative manner, particularly during their weekly team meetings. These meetings focused on shared decision-making about administrative issues, reading and discussing of scientific issues or debate of selected cases, discussion of the weekly team plan and communication of recent developments to the whole team. It was also reported that team members, through their shared work, were increasingly adopting a number of shared values about delivering care in an interprofessional manner.

from the Canadian government until the early 1990s. A key initiative, *Collaboration for Prevention*, encouraged health care organisations to implement several projects demonstrating how health care teams could work together and involve patients in decision-making. Building upon this work, the federal government (Health Canada) announced in 2000 that \$800m would be distributed through provincial and territorial agreements to support primary care providers develop collaborative approaches. Health Canada also recently launched a Pan-Canadian health human resources strategy to facilitate and support the implementation of an *Interprofessional Education for Collaborative Patient-Centred Practice* initiative across health and social care sectors (see Chapter 2). This followed recommendations in both the Romanow Report (2002) and the First Ministers' Accord (Health Canada, 2003) on reforming the health and education systems to become more collaborative and responsive to patient needs. Box 1.3 outlines a recent initiative aimed at improving patient care through the development of interprofessional primary care teams in one of Canada's largest provinces.

South Africa

The implementation of a district health system in South Africa in the 1990s resulted in a stronger emphasis on primary health care and an enhanced role for teamworking in primary care (South African Department of Health, 2001). Professionals are increasingly expected to collaborate in managing district health services and there is greater discussion of how professional and non-professional providers, such as lay health workers, can better work together in primary health centres. The demand placed on the health system by the HIV/AIDS epidemic has further emphasised the need to use the limited available human resources in the most effective way – a key issue for many low- and middle-income countries. The

Box 1.3 The family health team initiative in Canada.

Meuser *et al.* (2006) describe an Ontario-based initiative which was supported by regional government funding to establish interprofessional family health teams across the province. The initiative marked a departure from the traditional model of uniprofessional physician-based primary care towards one in which a team of health care professionals work together to address the local needs. The authors note that family health teams have a core of physicians, nurse practitioners and nurses, but can also include input from pharmacists and social workers. Team members work collaboratively to ensure that care can be coordinated and delivered in an effective and seamless manner. The overall goals of the family health team initiative include the provision of patient-centred care, improved access to care from a variety of health care professionals, an increased emphasis on chronic disease management, health promotion and disease prevention. The authors note that, to date, over 100 family health teams have been established, each at different stages of implementation. Teams were supported, it was noted, by the Ministry of Health's team guides that cover a range of issues, such as provider compensation, the use of information technology and ideas on establishing clear team roles/responsibilities.

extent to which this rhetoric of teamworking is reflected in changes to policies and practice is unclear, although some novel interventions to promote teamworking in primary care have been implemented. One of these initiatives is discussed further in Box 1.4, which describes a programme to improve teamwork and the delivery of primary care to people living with HIV/AIDS.

The United Kingdom

Interprofessional teamwork has a long history in the evolution of health and social care services in the UK. For Pietroni (1994), two nineteenth-century developments had a significant effect on the nature of modern teamwork. The first was increased government involvement in the delivery of health and social care and a desire within medical profession to delegate a range of their tasks. This, in turn, resulted in the increased involvement of professions, such as nursing and social work, in the delivery of care with physicians. The second was the 'militarisation' of acute care stemming from the Boer and Crimean wars. In response to the challenges of delivering care in the extreme conditions of warfare, medicine (and nursing through the influence of Florence Nightingale) employed the tactics of their military colleagues, including a chain of command, clear roles and hierarchy of decision-making. This approach to organising care was subsequently transported back to civilian life.

Focusing on the period following the formation of the National Health Service (NHS), Leathard (2003a) has traced a number of teamwork developments. She notes that interprofessional teams within hospital settings, particularly in

Box 1.4 The STRETCH Project in South Africa.

The STRETCH project – *Streamlining Tasks and Roles to Expand Treatment and Care* for HIV – aims to increase access to anti-retroviral drugs (ARVs) by encouraging nurses to initiate and repeat ARV prescriptions for uncomplicated patients and by integrating HIV and ARV care into primary health care services through interprofessional teamwork (Fairall *et al.*, 2008). Teams were set up at sites where nurses were prescribing ARVs. These teams involved pharmacists and physicians from the treatment sites and nurses from the ARV sites to provide logistics and support for prescribing nurses. Interprofessional teams were also set up with local area managers responsible for health services in that area in order to manage integration of HIV care services into primary care. These teams included pharmacists and nurses. To date, STRETCH has resulted in increased collaboration between physicians, pharmacists and nurses. It functioned less well when the physicians and pharmacists were based in a treatment site at a distance from the nurse-run ARV site. This was particularly difficult when there was a high turnover of pharmacists or physicians, which resulted in a lack of continuity. The teams set up to handle the integration of HIV care into primary care involved people already bringing primary health care services to the community. The services that they were integrating into primary care as part of the STRETCH project included drug readiness training, ARV preparation and monthly ARV care for those patients who had been stabilised at the ARV site. In areas where these teams worked well, they developed a strong sense of collaboration to bring services closer to people while trying to address practical issues such as training, staffing and suitability of facilities to be able to carry out the proposed integration. In some areas these teams did not succeed in working well together, particularly where there were many primary care clinics referring to ARV sites in large urban areas. Vacant management and coordinator posts also resulted in major logistical challenges for the existing ARV services.

departments of medicine and surgery, had traditionally formed the core of team-based interactions. However, in the 1970s and 1980s there was an expansion of teamwork into both mental health and primary care settings as a consequence of shifting government policies. More recent developments include, a focus on the use of interprofessional teamwork for patient safety (see Chapter 2) and an increased focus on the role of teamwork within obstetrics (e.g. O'Neill, 2008). Box 1.5 provides an account of a UK study which outlines a recent example of interprofessional teamwork within a maternity care context.

The United States

Like the UK, teamwork in the US has had a long and varied history. An early published example can be found in 1948 by Cherasky who described a *Team*

Box 1.5 UK-based interprofessional teamwork in maternity care.

Mackintosh *et al.* (2009) report findings from a qualitative study which explored the notion of ‘team situation awareness’ – an approach in which team members possess an awareness of their professional and interprofessional roles, tasks and responsibilities. Team situation awareness is noted to be a key factor in the patient safety literature, as it can contribute to safety by promoting effective decision-making, informed by knowledge of the available resources, and linked to the prioritisation and anticipation of tasks. The authors reported findings from a study of the nature of safety within maternity care, which gathered 177 hours of observation focused on teamwork and decision-making across four UK sites. Analysis of the data revealed that three elements were key to facilitating team situation awareness and team coordination – interprofessional handovers, sharing information by use of a whiteboard and a coordinator role (which involved the management of midwifery staff and was usually undertaken by a senior midwife). The authors found that the whiteboard acted as an important ‘viewing lens’ (p. 52) for physicians. The midwives, in turn, took ownership of the board to add and update clinical information. It was also found that the use of interprofessional handovers and the input of a coordinator were key to distributing information between team members. Collectively, handovers and the coordinator played a third and important additional role in providing *contextualising* information. The authors conclude that context, as well as the interplay between these three facilitating elements, were central components in affecting the quality of teamwork and the level of team situation awareness.

Home Care initiative – an outreach programme based at the Montefiore Hospital in New York State which involved teams of social workers, physicians and nurses (Casto, 1994). Other early developments took place at the University of Washington’s Child Health Centre in Seattle which involved the development of interprofessional teams consisting of physicians (paediatricians and psychiatrists), psychologists, nurses and social workers (Casto, 1994). Two notable teamwork developments were the Veterans Administration (VA) hospitals’ initiative, which in 1979 provided training programmes to teams working in geriatric settings, and the W.K. Kellogg Foundation, which funded a number of interprofessional team training initiatives in the 1980s. Box 1.6 provides an example of an interprofessional development aimed to improve teamwork between nursing and medicine.

The US has since witnessed a series of other teamwork developments as part of the quality and safety movement (see Chapter 2). Sorbero *et al.* (2008) recently described three current initiatives which have promoted interprofessional teamwork. The first, led by the VA hospitals initiative, involves 20 of its hospitals and was entitled *Transformation of the Operating Room*. This programme implemented

Box 1.6 The Magnet Hospital initiative in the US.

The *Magnet Hospital* initiative was nursing-led and promoted interprofessional collaboration and teamwork between nurses, physicians as well as other professionals. This model emerged in the 1980s from a policy study commissioned by the American Academy of Nursing during a time of major nursing shortages (Buchan, 1999). Magnet hospitals were intended to be organisations that attracted well-qualified nurses and offered enhanced nursing roles, job satisfaction and higher than average patient care outcomes (Buchan, 1999). In an evaluation of this initiative, it was found that the Magnet Hospitals were successful in both attracting and maintaining a qualified team of nurses who were willing to engage in new methods to solve problems. This, in turn, led to improved collaboration and teamwork between nurses and other professionals (Kramer and Schmalenberg, 1988).

surgical briefings and time-outs to help improve team relations. The second, led by Kaiser Permanente, set out to implement preoperative safety briefing in its 30 hospitals. This was intended to help improve team relations; reduce staff turnover and 'wrong-site' surgeries; and increase the detection of 'near misses'. The third initiative, led by the Institute for Healthcare Improvement, promotes teamwork through a number of activities. These include a perinatal programme which aims to improve care by applying teamwork interventions such as interprofessional ward rounds and team training opportunities. Another recent development has been the *Patient-centred Medical Home Model* which aims to enhance communication and teamwork, improve coordination of care, expand quality innovations and promote active patient and family involvement (American Academy of Pediatrics, 2009). (For those interested in reading a fuller history of teamwork developments in the US, see Baldwin, 2007.)

Professionals' experiences of teamwork

Having discussed a range of developments in relation to the health and social care professions and their approaches to teamwork, we go on to present a variety of accounts of professionals' *direct experience* of interprofessional teamwork. These vignettes are based on brief semi-structured interviews or email exchanges with colleagues in the field. Specifically, they highlight the range of successes and challenges encountered in different clinical contexts across the world when working in interprofessional teams. We have included them as they provide experiential accounts which help ground and contextualise the more conceptual and theoretical materials we present later in the book.

Successful interprofessional teamwork experiences

Below, nine different professionals reflect upon some of the key successes they have experienced when working in interprofessional teams based in different parts of the world.

In Australia:

In a successful team there's the satisfaction of knowing that the team has performed well even when there have been difficulties associated with the work such as uncontrolled bleeding or a prolonged case. There's also the knowledge that the patient has received the best care possible, and that during the surgery the team worked cohesively together – its 'poetry in motion' to watch. (Nurse, Australia)

As a cardiothoracic surgeon, I am involved in interprofessional teams every day of my working life. In the main, my experiences of teamwork have been very positive. The main successes with interprofessional teamwork have been building up a successful heart and lung transplant/circulatory support service at my previous hospital and at my current institution. Both resulted in excellent patient care and outcomes. (Surgeon, Australia)

In Canada:

With effective teamwork there is a mutual respect for others' contributions. Nursing is seen as important because we spend time with the patient and their family. The rest of the team relies on the nurses for greater understanding. Once the team was familiar that we (nurse practitioners) are not a replacement – they know there is a difference. They can make referrals and there is a real need for nurse practitioners to be involved in patient cases. (Nurse practitioner, Canada)

A holistic approach to health management ensures that the client's assessment and treatment is not subject to splinter areas (e.g. wound care without positioning, bladder re-training without exercise, chemical restraints without trials of alternative measures). Additional successes are sharing of resources, knowledge, product information, sharing of past experience and practises. Efficiency and competency in practice is another by-product of an interprofessional team. Workload sharing and stress reduction is also a significant factor in teamwork. (Occupational therapist, Canada)

In general, my experiences of interprofessional teamwork have been positive. I am part of a family health team. I have always worked closely with nurses. We have now also added a pharmacist, nurse practitioner, dietician and diabetes nurse educator. So the team has grown in last few years. The team is committed to expanding. In fact, the pharmacist has really been a lynch pin. Incorporating her individual and her complementary knowledge has been fantastic. It is mostly due to the team's excitement and openness. (Physician, Canada)

In Norway:

I have had numerous experiences with interprofessional teamwork during 15 years of social work in Norway. Mostly, it has functioned well and improved the client's and their family's situation. Interprofessional teamwork also gives an opportunity to coordinate

efforts and have mutual reflections on how to understand the service user's situation which can be very complex. (Social worker, Norway)

In South Africa:

I have had a strong interest in interprofessional teamworking, which developed from my early work in mental health – a clinical area which encouraged teamworking at a much earlier stage than other clinical areas in South Africa. One important early influence was a professor of psychiatry who felt strongly that nurses should be equal partners in caring for people with mental illness. I was encouraged to use and develop my skills and did not ever feel inferior within the team or experience a lack of trust. The culture was that all professionals could contribute but that each was accountable for their actions and would take responsibility for them. (Nurse, South Africa)

In the United Kingdom:

My teamwork successes have included working with mental health service users, their carers and all the professional staff in health and social care. Through listening to all stakeholders and staff, through discussions, assessing, planning, prioritising, checking that resources are available agreement can be reached on the approach to care, support and delivery. This results in teamwork which ensures the delivery of well co-ordinated health and social care services. Working in a team and looking after very disturbed, difficult, aggressive and sometimes violent people, the teamworking approach made the area safe for service users and staff. The service users benefited from a positive environment where they knew who could provide what; and the staff benefited from having a common care approach. (Nurse, UK)

In the United States:

When interprofessional teamwork is successful, patients, families, institutions and professionals benefit. Teamwork is not an intuitive process. It requires education, skills training, ongoing clinical collaboration, and institutional support. It requires time for communication. Professionals need to understand and value the competencies and strengths of each and utilise these competencies to best serve patients. Within each patient situation a different profession may be required to take the lead. Teamwork that functions well allows for leadership to be fluid. It is not always the physician who knows the patient's needs best. However, the professional who best knows the patient may not necessarily know what the patient needs. Teamwork allows for the kind of communication, collaboration and cooperation that sidesteps personalities and works for best patient care. All members must be open to learning from each other and growing in their respective roles. (Social worker, US)

As indicated above, these professionals' reflections on successful teamwork are varied. Highlights of these strengths include coordination of efforts, the need to listen to one another, mutual respect, a commitment to the team, and motivation to learn and share from each other. Importantly, leadership has to be fluid in order to promote effective teamwork and deliver safe, high quality care.

Challenging interprofessional teamwork experiences

In this section, our nine professionals go on to reflect upon some of the key challenges they have encountered when working in different interprofessional teams.

In Australia:

Differences in professional identities give rise to the 'silo' mentality and reduce team cohesion. Although roles within the team are very well-defined, there are times where they overlap and some members may need to compensate or assist more depending on the situation. Additionally, power differentials may stifle communication because lesser experienced members may be reticent to speak up or to ask for clarification when it's necessary. (Nurse, Australia)

The main challenges I have experienced with interprofessional teamwork have been getting all groups on board within the surgical setting. There was initial scepticism about teamwork, but subsequent acceptance emerged. (Surgeon, Australia)

In Canada:

The challenge of effective teamwork is getting existing teams up to speed. It takes time and effort to change the culture. It is really a cultural shift. We have to expose them to teamwork principles. We have to be prepared to move forward. I am not sure that we are good at convincing professionals that it is good to do, or that they are not doing it already. (Nurse practitioner, Canada)

The main challenges on any given team in my experience have been related to personality conflicts, a change in team membership, varying levels of competency or incompetency, absenteeism, inefficient time keeping during meetings and team members who do not think they can learn from others. When the team dynamics change or the team leader becomes more administratively focused and less action orientated, it is a stressor. Health care trends impact on teamwork. Especially with the recent flu outbreak and infection control monitoring in general, these stressors seem to take away from team planning time or meeting time in order to deal with 'acute' situations. (Occupational therapist, Canada)

The biggest challenge right now is integrating the nurse practitioner into our team. We need to figure out what her scope of practice is and then how to integrate it so that it is appropriate for the team. It is important to have that net gain for the team. So, for example, if she is always doing something that needs a consult, then that does not benefit the team. So now it is just figuring out where she fits. It was an easier fit for the dietician and pharmacist who already had a better sense of their scope of practice and how they fit in, but we all are open and work together. (Physician, Canada)

In Norway:

Sometimes interprofessional teamwork has functioned poorly, mostly due to lack of resources. Usually lack of time has been an argument for not giving teamwork the necessary priority. In Norway, interprofessional practice is mandated by the law in our work with children. Perhaps there is an idea that all the professionals will work in a collaborative way, which is not always the case. There is often little support from leaders and the professionals think that interprofessional work is not their responsibility and choose to work more traditionally, which means more individually. I also think we need to focus on interprofessional teamwork during health and social workers' education in order to develop a collaborative attitude. (Social worker, Norway)

In South Africa:

There are number of barriers to teamwork. First, the hierarchical structure of nursing, in which nurses manage themselves at the policy level in opposition to other

professional groups. This reinforces professional divides. Nurses at the clinical coalface are influenced in subtle ways by these divides at higher levels. Furthermore, physicians are often brought in as 'experts' to teach nurses, while other professions are not given the same status. In addition, medical training teaches doctors that they can only trust themselves and does not generally encourage them to value the opinions and judgements of other professionals. There's also a sense of 'us' and 'them' – a 'leitmotif' in the South African context which is drawn along multiple lines, including race, gender and profession. (Nurse, South Africa)

In the United Kingdom:

One of the main challenges is dealing with conflict at work – once conflict arises the professionals tend to rush to their profession specific mode. Challenges arise when conflict is related to users, carers and staff. We need to get staff and users to understand that working in a team does not mean giving up their initiatives and decision making to a committee. We need to get staff to work under the leadership which is different from the usual person; getting all the staff to have a common view towards diversity, discrimination, oppression, religion, stigma, gender, ethnicity and race. However it is difficult to get staff to address these challenges. (Nurse, UK)

In the United States:

Interprofessional teamwork is less positive when it is merely a collection of professionals throwing out ideas rather than listening and learning from each other. This happens most often when one member of the 'team' perceives his or her perspective to be most important – when being right surpasses the desire to do what's best for patients. This also seems to occur when a professional or the professional culture does not have an investment in interprofessional work and neither understands nor values input from other disciplines. I've seen patient care jeopardised when teams do not value interprofessional communication. I worked with a paediatric palliative care team that consisted of an oncologist, nurse, social worker, child development specialist, and chaplain. The oncologist and nurse worked together but rarely consulted with the social worker. The social worker had most contact with the children and families but her opinions were not valued. Further, she felt marginalised by the medical professionals. (Social worker, US)

As indicated above, these professionals have outlined a variety of teamwork challenges. Many are underpinned by the power differences that exist in interprofessional teams, which can limit communication and promote friction between members. Other challenges include an uncertainty of how each member 'fits' in the team and pressures on members due to a lack of resources such as time. It was also suggested that limited interprofessional education opportunities may be responsible for why many professionals do not listen to and learn from each other.

Conclusions and implications

Interprofessional teamwork, as we have discussed in this chapter, emerged in a number of countries at different times and in different ways. Despite these differences, it is possible to see that the emergence of teamwork, across these contexts,

was related to a common need from policy makers and practitioners – that teamwork could help address problems of service delivery which were rooted in poor interprofessional coordination and communication. However, effective teamwork has been found to be a difficult goal to achieve, as it involves a diverse set of requirements, including the need for clear team goals, shared commitment and interdependence, ongoing teambuilding efforts, open communication, regular team meetings, as well as mutual respect. The complexities which were described in the teamwork literature were echoed in the professionals' direct accounts of interprofessional teamwork, which also included a range of intricate factors related to both their positive and more challenging teamwork experiences. Indeed, it is this complexity which underpins teamwork that we go on to examine and discuss, from a number of angles – theoretical, empirical and practical – in the rest of the book.

In this chapter we offered a range of introductory materials to begin to understand the width of the different conceptual, political, historical and experiential elements related to interprofessional teamwork. From this starting point, we go in the next chapter to explore how teamwork has moved to occupy a central position within many health and social care systems as a key approach to enhance the delivery of care.