Interprofessionalism and ethics: consensus or clash of cultures?

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Summary   *The ethical arguments which underpin the call for interdisciplinary collaboration are analysed. In particular, the concept of 'teamwork' is considered as well as the organisational, professional, personal and cultural obstacles that constitute the barriers to the effective development of interdisciplinary relationships.*

Key words: *Ethics; teamwork; interprofessionalism; power.*

Introduction: ethics, law and interprofessional care

The promotion of interdisciplinary approaches in the delivery of health, welfare and educational services has long been regarded by planners and practitioners as a worthy end to pursue, in the hope that it would have a positive impact upon the quality of services that the public receives. Calls for greater interdisciplinary contact place complex conceptual and practical demands on service providers to co-ordinate their practices through the development of co-operative interdisciplinary and interagency relationships. At the service delivery level, workers are exhorted to work co-operatively with each other; develop, multidisciplinary 'teams'; and, integrate their services as and when the need arises (World Health Organisation, 1988). But success in achieving multidisciplinary relationships has proved elusive. A review of the empirical literature on multidisciplinary 'teamwork' in health care settings suggests that the relationships between service providers remain variable and complicated (Gregson *et al.*, 1991; Kilcoyne, 1991; Loxley, 1997). Similar findings have been reported with respect to interprofessional education (Barr *et al.*, 1999; Zwarenstein, 2001a). Even where participants recognise their interdependence, there has been only limited success in terms of health outcomes such as length of stay, in improved co-ordination and integration of services, or in the number of consultations between social actors (Gray, 1985; Irvine, 1985; Zwarenstein, 2001b). Interprofessional relationships continue to be characterised by conflict rather than co-operation and are frequently distorted by mutual suspicion, hostility and disparities between the way that a particular profession views itself and how it is viewed by other occupations (Bernhofen & Opie, 1997; Cott, 1997; Griffiths, 1997, p. 262).

  Ethical critiques of health care frequently adopt one of a number of normative ethical approaches, including 'principle-based', consequentialist, deontological or virtue-based ap-

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proaches. While this may be appropriate when examining specific clinical ethical issues, such as consent or the assessment of competence, none provides a sufficient basis for understanding the complexities of interprofessionalism. We believe that interprofessional care cannot be understood without appreciation of the multiplicity of subject positions, both between health care professions and within them. This approach has its philosophical roots in French structuralism, post-structuralism and post-modernism, and stresses the significance of history, linguistics, discourse, social context, difference, institutional structure, culture and power in society and in medicine (Best & Kellner, 1991). This approach also does not advance a single method or ethical theory but accepts that a number of different approaches, including sociological analysis, legal analysis, stakeholder analysis (Chambliss, 1996), ethnography (Fox, 1989), discourse theory (Percheux, 1982) and systems perspectives (Briggs, 1999) may be required to understand properly the complex nature of interprofessional relationships. In this paper we use such approaches to address the basis of interprofessional care, the notion of teamwork and the structural and cultural barriers to teamwork and interprofessional collaboration.

The basis of interprofessional care

Changes in the health care sector over the past two decades have been driven by an increasing emphasis on measurable outcomes, best practice, continuity of care and cost containment. This has led, in turn, to calls for greater adoption of clinical pathways and for interprofessional models of care to replace traditional models of health care delivery based around the sole medical practitioner. A number of ideological, practical and political explanations can therefore be identified to explain the emergence of interprofessional care.

Ideology

The call for interdisciplinary collaboration has its roots in shifts in practice ideology. The (re)discovery of the 'whole patient', during the 1970s, provided an impetus to re-think the relationship between the myriad of new medical specialists and allied technologies and professions. It was recognised that patients/clients often present with multi-factorial problems that few agencies acting alone can address. Patients and clients may also present with needs that can be defined as both 'medical' and 'social', and so require 'broad' care. It was increasingly felt that complex patient needs could best be met by securing greater co-operation between service providers and by the synthesising of professional social formations which integrated a range of interdependent but separately administered services (Department of Health and Social Security, 1978).

Separatism

Materialist arguments have also been mobilised in support of multidisciplinary approaches to health service provision. Reform of the government's role in delivery of health care and greater attention to market economics and the commodification of health have placed a demand on service providers to use resources to best effect and to get value for money. These conditions are generally not tolerant of interagency and interprofessional separatism. In contrast, co-operative arrangements held out the prospect of reducing duplication and/or 'waste' and prompted intense searches for signs of duplication of effort that might enable the profession or the agency to limit their own commitment to a particular activity. The hope of eliminating 'gaps' between services and 'bottlenecks' in communication encouraged the view that effectiveness would be enhanced through co-ordinated planning and the establishment

of collectively agreed priorities. Multidisciplinary practice was viewed as a panacea for inefficiency in health service delivery, for communication failure within and between disciplines and for professional separatism (Irvine, 1985).

Specialisation

The pressure for improvements in interdisciplinary relationships has also been impelled, in no small part, by studies that have shown that the provision of health, welfare and education services is fraught with internecine and interprofessional conflict, dissension and misunderstanding (Greenfield, 1999). While there are many reasons why inter- and intraprofessional conflict occurs, increases in functional specialisation in the health sector have been identified as a major source of tension.

Since the turn of the twentieth century, generalist workers have been replaced progressively by a diversified range of occupations and specialists focused on particular fields of work, particular problem areas, particular processes or client groups (Abbott, 1988; Horowitz, 1970). The reform of health care systems and the emergence of evaluative systems and apparatuses also contributed to the multiplication in the number of social agents both directly and indirectly involved in the delivery of services to the public (Feinglass & Salmon, 1990; House, 1993). This professional and functional specialisation fragmented knowledge and expertise and contributed to the growth in a complex social and technical distribution of knowledge and labour in health. Specialists or 'experts' now have a more detailed understanding of, and information about, substantive issues they deal with than at any time in the past and so 'own' a socially defined body of 'core' knowledge that is central to their tasks and duties. This role-specific knowledge includes not only factual and theoretical knowledge, but also 'knowledge' of the various norms, values and beliefs that constitute the profession. As a result, it is no longer possible for any one profession to master completely and adequately all of the knowledge that is currently available in their sphere of work. Nor can they lay *exclusive* claim to have all of the knowledge and skills necessary to address a particular need, issue or problem. Every profession and expert system necessarily overlaps other professions and expert systems.

Yet it was clear that service providers tended not to acquaint themselves with alternative systems of knowledge outside of their discipline and failed to establish arrangements to draw on the specialist skills of others in adjacent but different occupational fields (Huws Jones, 1971). Professionals were not reconciled to the possibility that their knowledge and expertise concerning a subject was less detailed and more simplistic than that of others working in complementary disciplines. Professionalism appeared to foster a kind of myopia as each profession developed its own perspectives and self-perceptions.

Health care teams and the concept of 'teamwork'

Against this backdrop a countervailing belief began to emerge that progress in health care service delivery could only be made by professionals ignoring socially constructed disciplinary boundaries and forging new interdisciplinary networks to link discourses and the activities of diverse personnel. New arrangements were required which promoted the social process of communication, co-operation, co-ordination, collaboration and integration for the purpose of exchanging ideas, expertise, theories and perspectives. Short of developing an entirely new profession which incorporated medicine, social work and nursing (Rubin & Bradburn, 1976), increasing attention was turned to the ubiquitous but ill-defined concept of the health care 'team' as the best means for advancing interdisciplinary relationships (Katzenback & Smith, 1993).

'Teamwork' held out the promise of providing shared services for addressing patient or client needs. It was anticipated that it would promote clearer definitions of client/patient needs(s) and interests, and lead to improvements in the deployment of scarce and costly services. At the professional level, it was also anticipated that teamwork would expedite a more critical self-reflexive approach to health care and a more intense interrogation of professional theories and practice.

One of the goals of teamwork was to provide the worker with additional material to synthesise new ideas and develop their capacity to think critically and 'holistically' in regard to clients and their circumstances. In addition, teamwork was to provide new opportunities to health workers to enhance their stock of knowledge and understanding of the collective expertise and resources that were available, where they were to be found, and how they may be utilised appropriately and efficiently. Rather than working in parallel, it was hoped that teamwork would expedite the co-ordination of professional practices and actions, lay the ground-work for shared responsibility in client care and create the conditions for the referral of those in need of alternative, but complementary, services to others who may be better placed or better equipped to deal with the client's needs. Unsurprisingly, the team concept found enthusiastic advocates both amongst planners and front line personnel who viewed the approach as a possible solution to the problems arising from traditional hierarchical relationships in the division of labour.

Structural barriers to teamwork

It should not be assumed that instructing workers to collaborate with each other in the interests of those they serve will be sufficient to bring about effective teams able to provide improved services. A variety of barriers to interdisciplinary relationships exist, both in theory and in practice, that inhibit the construction of close collaborative relationships at the grass roots level of service delivery.

Professional divisions

The social division of planning is a major contributor to the difficulties that routinely confront service providers, locating the problem far from the day-to-day business of local professional practice (Booth, 1983). In many countries the division of authority for the provision and delivery of health and welfare services between federal and state governments or regional administrations complicates the development of interdisciplinary contact and communication. The separation between social, health and economic policy making may also exacerbate the problem of ineffective interdisciplinary contact and communication. Lack of political support and financial aid from the host institution(s) and changing political or budgetary priorities have each been linked to the failure of programmes specifically designed to establish collaborative interdisciplinary relationships. At the level of strategic and operational planning, authorities lack coherent policies for formalising channels of communication across boundaries and fail to engage in forward planning and preparation. For want of better management, the good will of social agents on the ground has been squandered. Positive initiatives have to be made to foster interdisciplinary organisation and relationships.

At the service delivery level, the emergence of complex 'teams' appears to have done little to resolve issues revolving around the organisation of control over work. Professional structures are differentiated by: demographics; the size of the occupation's membership; gender composition; the class of origin of its members; educational attainment; status; and, the relative size and source of primary income. These variables have been cited as obstacles

to the development of interdisciplinary collaboration and co-operation in the health and welfare field.

Authority and division of labour

Authority structures and the division of labour continue to reflect basic structural differences found in traditional health care facilities and wider capitalist society. Traditionally decision-making power and authority are concentrated in the hands of a professional elite, with the discipline of medicine at the top of a pyramid. Medicine is a long-established, large professional organisation whose members are drawn predominantly from a well-educated, small, upper-class who can command a high income and high status (Navarro, 1976). In contrast to this, social work, occupational therapy, and speech pathology, for example, represent relatively young occupations with a young membership, the majority of whom are women who are drawn from a variety of social class backgrounds with less educational attainment. These structural variables may shape and inform attitudes of one occupational grouping towards other occupations and collaborative work. The raw power of medicine, combined with a high degree of professional self-confidence developed by doctors and consciousness of these differences in prestige amongst other occupational groups, contributes to a degree of mutual wariness and defensiveness as each occupation attempts to defend its own territory.

For most of the twentieth century the health division of labour has been organised and hierarchically structured around the dominant profession of medicine (Freidson, 1970). Thus the medical profession was invested with authority to supervise, direct and co-ordinate the work of other occupations. Indeed, as Freidson has observed, professionalism is, in one sense, a strategy of job control in which 'one of the main prizes is the right to define and determine situations in a given sphere of work' (Freidson, 1970). However, over recent decades medicine's claims to autonomy and dominance have been increasingly challenged by non-medical groups.

Subverting medical dominance

The teamwork concept has underpinned attempts by subordinated occupations to resist, subvert and re-structure traditional relationships of medical dominance (Griffiths, 1997; Irvine, 1985). For some advocates of teamwork, one of the guiding principles of collaboration and teamwork is power sharing and shared authority in a more democratised social relation-ship (Horowitz, 1970, p. 12) in that the term implies a degree of social equality whereby occupations attain an 'equal footing' (Cott, 1997, p. 1412). The 'team' has thus become a discursive and practical instrument of deciding the question of the division of labour in the favour of non-medical workers. In theoretical, political or organisational terms, the idea of teamwork promised to empower various professional groups such that they had a more prominent role in decision making and the provision of services. As multidisciplinary team practice became more widespread and non-medical groups began to assert their professional 'interests', doctors claimed that they were the 'natural' leaders of the team. This status claim was justified on the basis that the doctor could point to a rich, powerful and 'scientifically valid' corpus of knowledge, had superior knowledge of the key factors of the clinical situation; had the ability to treat illness and co-ordinate the work of other subordinate staff and had primary legal responsibility for the continuing care of patients. Indeed, as Cott (1997, p. 1412), citing the research of Temkin-Greener (1983) and others (Illich, 1977) has noted, medicine embraced the idea of teamwork 'as a means of maintaining control over other health professions'.

Rather than promoting more egalitarian and collaborative social formations, health care teams tend to reflect, reproduce and perpetuate the traditional divisions of labour, status systems and systems of authority.

Conflicts over authority, power, control and jurisdiction (deciding who is responsible for providing what service) pose an undeniable barrier to effective collaboration and teamwork, particularly when occupational groups attempt to defend activities that are thought to be strategic to the maintenance of their professional identity. The persistence of medical dominance in teams and 'top-down' approaches to interdisciplinary relationships continues to be a source of considerable tension for non-medical groups who may question the legitimacy of the medical profession's overt claim to 'professional dominance' and authority over matters to do with health and illness.

Professional organisation

Professions also differ in the arrangements they adopt to accomplish their work and in the way they work, creating yet another barrier to effective teamwork. Differences in the structure of the working day or office hours may inhibit the formation of close working relationships and trigger hostile responses (Cott, 1997). Meetings may be scheduled at times that are inconvenient to other workers: general practitioners and community workers, for example, may work late into the evening and plan their time to suit the needs of patients and community members, rather than to accommodate an institutional timetable and the needs of bureaucracy. Service providers may also differ not only in terms of their schedules, but also in the time-lines they follow to complete specific tasks. Doctors may work swiftly and make a myriad of assessments and decisions for their patients each day, whereas social workers may undertake long-term casework with a small number of clients. This too may be a potent source of professional misunderstanding and conflict.

Different value systems

Differences between the professions may become especially problematic in cases which the referral agent defines as 'crisis situations', i.e. those requiring a rapid, concrete response or decision. When other professionals apply their own frames of reference to make sense of a situation or condition, they may differ intensely over the priority the case is assigned. Certain categories of person and certain complaints are rank ordered from those deemed to be of high priority, requiring immediate attention to those which may be effectively ignored, passed on to another agency, or acted upon at a later date. Problems may also be re-defined, including whether the issue is one of prevention rather than treatment. The use of such priority systems may be a source of conflict when workers do not share the same priorities or values, when the original problem is deemed to have been ignored, devalued or dismissed, or when feedback after referral is poor.

Another source of tension and confusion stems from the nature of work with clients. Health care workers provide treatment that is visible both in practice and effect, whereas the modes of practice undertaken by social workers and community workers are less conspicuous and interdisciplinary judgements about the methods used may be a source of conflict or professional rivalry (Irvine, 1985; Tebbitt, 1975).

Legal effects

Professional differences have also been reinforced by various court decisions. Decisions by English courts in the early twentieth century emphasised the responsibility of medical

practitioners and the subservient relationship of nurses. Judgements such as *Hillyer v Governors of St Bartholomews Hospital* [1909] 2 KB 820 stressed the superior responsibility of the medical profession. It was not until the 1950s that the English courts began to reassess the responsibility of hospitals and their staff. In *Cassidy v Ministry of Health* [1951] 2 KB 343, Denning LJ commented on the earlier judgements (including *Hillyer*) and said that they were motivated by a desire 'to relieve the charitable hospitals from liabilities which they could not afford'. It is unfortunate that the earlier approach still has some influence on attitudes to the responsibilities of, and relationships between, those offering care to particular patients.

Variations in the ways in which different professionals must be registered before being able to practice also impact on the approach and perception of health workers. Most jurisdictions have legislation requiring persons to be registered before they can practice their professions. The purposes of registration are many, but the primary purpose is said to be to protect the public from unqualified practitioners. One of the effects of professional registration is to 'legitimise' a particular group of practitioners. This is one reason why there may be resistance to a group such as alternative practitioners from being registered as a professional group.

Cultural barriers

'Intellectual baggage'

Organisational differences reflect different professional cultures whereby each profession may define and/or explain any situation in qualitatively different ways. While certain phenomena might be of common interest and concern to a wide range of service providers, they may attempt to make sense of a situation or problem and formulate a response to that 'problem' in terms of their own frame of reference. Indeed, differences in the interpretation of 'problem' behaviour and its causes underlie the major professional perspectives and inevitably lead to varying approaches to 'treatment' and to the issues that are given priority. Take for example the problem of heroin addiction. Social workers, the police and health care professionals may define the problem either in terms related to personal deviance or personal responsibility, or locate addiction in the confluence of environmental and genotypic factors. Models that depend on an interpretation of behaviour as individually caused and the result of individual pathology, more easily fit into a role definition that requires the worker to socialise the client into the existing social order rather than challenge it. This may be manifested in the legal requirements attending supervision of the mentally ill, and of those in need of compulsory measures of care, but also, more subtly, through the labelling of individuals and families as 'problems'. In such instances, service providers will focus their energy on the identifiable and labelled problem.

Community workers, on the other hand, might interpret the use of heroin as a structural problem and give a central place to environmental factors and theories of causality. Thus, community workers may see legislative reform legislation or institutional change as a legitimate part of their work. 'Treatment' therefore is conceptualised in terms of institutional modification rather than personal adaptation.

Language

Terms used in one human service profession are often in common use in another. Unfortunately, rather than creating a base for satisfactory communication, shared terminology can intensify confusion and resentment since not only do these terms have different connotations for each profession but they may also signal crucial values. Communication between workers is clothed in jargon with its own particular and exclusive meanings and all professions

fabricate esoteric language that is inaccessible to those outside of the discipline. This can be a source of misapprehension and misunderstanding between service providers. Terms such as 'culture', 'maladjustment' and 'deprivation' have different meanings and entail different responses from health workers, social workers, community workers and teachers, depending upon whether 'maladjustment' is conceived as located in the client or the institution. Major assumptions about the nature of society and the role of the professional underlie the use of such terms and differentiate the professions. Thus, common terms that seem to draw together human service workers, insofar as they are related to differing conceptual frameworks and to differing roles and tasks, may serve to endanger rather than enhance the capacity for interpersonal co-operation.

Intraprofessional variation

Stereotypes and their associated value base have been devised to categorise a complex world; they form part of professional apparatuses for making sense of a complex division of labour. But not only are they over-simplified, they also fail to take into account variation within professions. Within each profession there is a considerable diversity of opinion on its aims and roles, and the methods of interdisciplinary work. The diversity within professions holds out both problems and prospects for collaborative work. It can be the source of additional confusion and resentment in the course of interprofessional exchanges and 'pre-emptive strikes' on the basis of erroneous expectations of uniformity may sabotage all opportunities for harmonious communication. Anticipation of intraprofessional variety should ideally help the intending co-operator to exercise patience through the early stages of negotiation and exploration while the basis for personal as well as interagency relationships are established.

Identity

There are of course genuine conflicts of interest as well as conflicts of value. Those whose livelihoods are affected will be highly motivated to protect their interests (Bjorkman, 1985). Unfortunately, the more explicit the link between conflict of interest and conflict of values, the more difficult it is to resolve the conflict through negotiation (Tysoe, 1982). However, even without conflicting interests, intergroup competition can arise as each group strives to acquire or maintain its own social identity within the team setting. In the political economy of human services, organisations promote their own programmes and activities and seek to preserve their own organisation's sphere of influence and of operation while retaining their own resource supply. In fact, in order to maintain distinctive identities and protect their independence, professional bodies are apt to stake out boundaries against the encroachments of others. It is from this point of view that the reluctance to share confidential, or indeed any, information with members of other professions can be explained. The guarding of information in these terms can be construed as a means of declaring a boundary rather than a means of preserving clients' privacy. The 'gate-keeping' practiced by most professions to keep not only other professionals but even their clients at bay may similarly serve this function, establishing control over access as well as control over resources. Given such strong motives for independence or control, it is little wonder that many professions are ignorant of other professions' procedures and purposes and the demands their work makes on them. However explicable, this ignorance provides a serious stumbling block to co-operation if through lack of knowledge of complementary skills and resources no contact is made on issues of common interest and importance.

Many, perhaps the majority, of workers, recognise their own and their profession's limitations as a whole, and acknowledge the constraints on their functioning. Yet they may

set unreasonably high expectations, derived from ideal typifications, for other practitioners to solve intractable problems. This often leads to judgements of failure when their expectations are not fulfilled. The gap between idealised expectations derived from ideal types is heightened by the frequent false claims of the other profession. Stereotyping is common and has a functional purpose for each occupation in preserving its social identity as a discriminable and valuable social group. In a complex professional world, simplistic evaluations of each profession's role also serve as boundary markers and as defences against uncertainty. However, the effects of negative stereotyping and over-simplified and unreasonable expectations are dramatic.

Professionals may lack interest in developing either interdisciplinary or interagency relationships, giving priority to other aspects of their job, such as helping people with personal difficulties. Or, they may regard investing in the development of interdisciplinary relationships as too costly if they run the risk either of being accused of disloyalty to their own profession group or appear to be working against its immediate interest. For workers who are already struggling with the unwelcome and sometimes enforced requirements of role subordination, this may come as an added blow. Co-operation at a personal level is therefore not always easy to achieve, however much it may be encouraged.

Training

The training and education professional workers receive may have constructive or destructive effects on later interprofessional work. Professions create their own distinctive cultures through their training procedures and the pronouncements of its professional bodies and through on-the-job socialisation. Neophyte professionals acquire, through their education and training, a manner of conceptualising facts, definitions of clients, causal explanations and views on treatment. Such 'facts' include definitions of the situation, the person (patient, client, community, organisation, citizen) and the person's problems. Later, these 'facts' shape and inform professional interventions and the approach to these interventions. In their training, students are socialised into the types of role relationship expected within their work situation. Not only does it provide the rationale for the professional roles and tasks, and the methods by which they may be carried out, but the internal pedagogy of competitiveness and manipulativeness often form part of the educational experience of many students; characteristics which are associated with difficulties in collaboration (McMichael & Irvine, 1983).

Conclusion

It is not difficult to accept the need for a greater degree of co-ordination and co-operation between various professions operating within the field of human service provision and support, whether in the spheres of medicine, social work, education, or the social services. However, agreement in principle does not automatically guarantee co-operation in practice. Calls for increased emphasis on 'teamwork' and co-operation have been a feature of a multitude of government reports [most recently Bristol Royal Infirmary Inquiry, (2001)] and yet the reality of relationships in the field has not altered significantly. Indeed, many such recommendations have a Utopian ring in light of the arguments that we have advanced with respect to the impact of practice boundaries, the particularity of knowledge and values, professional protectiveness, myopia and power seeking, and the divided nature of governmental social planning. Successive national governments have sought to improve the quality and contain the costs of health, welfare and educational services by demanding that professionals and their agencies intensify their efforts to establish productive, interprofessional. relationships. In Britain this desire has, according to Hackett & Spurgen (1997), led the Blair

government 'indiscriminately' to encourage health service personnel to cultivate a 'teamwork culture'.

Professional ethics is a force which impels the reform of interprofessional relationships and the establishment of 'team' approaches to service delivery. Throughout the modern period the professions have justified their authority, status, autonomy and incomes by claiming moral exceptionality. Starting with the Hippocratic oath and extending to contemporary professional codes and declarations of ethics, they assert that professionals make the interests of their clients their first consideration. All modern health, welfare and educational professionals therefore position themselves at the same, rather than opposite ends, of an ethical continuum which is based upon the universal claim to be strongly committed to an ethical stance which stresses the primacy of the client's needs and interests over their own.

Yet, the continuing failure of service providers and institutions to forge, develop and maintain effective 'teamwork' relationships must cast doubt on the legitimacy of professional claims to serve the client's interests. For those who doubt this assertion, and the potential impact that such failures can have on clients' lives, the Bristol Royal Infirmary Inquiry (2001), to say nothing of the findings of a succession of reports of committees of enquiry into the care and supervision provided to children at risk of abuse, including the inquiry into the murder of Victoria Climbie, makes instructive and harrowing reading. The realisation that one's profession or agency alone cannot provide for all of the client's health and welfare needs places professionals under a moral obligation to co-operate with others who may share a professional responsibility to alleviate hardship and suffering in individuals, families, groups and communities.

There is little doubt that health professionals must become more adept at minimising the impact of territoriality, managing practice boundaries and learning mechanisms for harnessing the conflict that is probably an inevitable feature of teamwork and interprofessional collaboration. And yet advances in these areas are unlikely to occur if attention is given only to issues of interprofessional dynamics without attending to patterns of interprofessional communication and the impact of culture and organisational setting in determining the function of health care teams (Boaden & Leavis, 2000).

At this point in time it is clear that professionally based education and training systems have failed to deliver the interprofessional agenda (Herzberg, 1999). While it may be too much to expect, interprofessional training, whether through joint in-service courses, through cross-placement of workers, or through providing opportunities to learn about other agencies and acquire the skills of collaborative operation, via observation and supervised experience, seems a likely starting point for surmounting the obstacles to co-operation. Certainly an argument can be made for providing more blocks of combined training to cover such matters as professional responses to common ethical and legal dilemmas, people with special needs, the impact of poverty and disadvantage on patient populations, and the importance and impact of multi-cultural society on health and patient behaviour. From the first year to graduation, students from different disciplines need to be given opportunities to work together. (Again, see Bristol Royal Infirmary Inquiry (2001)). However, the problem remains that they have little time and opportunity to meet regularly before and during their course of study and placements. Cross-organisational placements may also need to be developed to increase familiarity with people of different occupational structures and cultures at this as well as at the in-service stage of training. Training for already qualified professionals who have fully internalised their occupational ethos without having acquired a means of analysing the place of that ethos, and its professional function within a framework of organisational theory, may encounter insurmountable hurdles unless carefully handled.

For better or for worse, the suzerainty of the doctor and the old medical order is gone and will not return. Health care is now characterised by a complex and variegated ensemble of

professions and practices. This creates conflict and confusion but also new possibilities for the construction of social and professional groupings of real meaning and significance. Whether these opportunities will be realised through education and training, and what they will mean for the delivery of health care and for the social and moral construction of the professions, remain to be seen.

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