Blurred boundaries damage inter-professional working

Everybody pays lip-service to the idea that healthcare professionals should collaborate in delivering care to patients. In this article, Rosemary Rushmer explores how a new methodology, connate theory, could lead to improvements in our understanding of what makes healthcare teams tick.

Introduction

The need for effective teamworking in the NHS

As far as patients are concerned, health services are delivered by professionals working collaboratively. Patients move from one professional group to another in receipt of services designed to meet their clinical needs. The organisation, deployment and effectiveness of these collaborative networks are in-house issues, mainly invisible to the consuming public. This paper addresses those hidden aspects of health service provision, in looking at the arrangements made between health professions to work together in delivering those services.

As early as 1974, the term the ‘primary care team’ appeared (British Medical Association 1974). It reappeared as a term of wider inclusion across the NHS, the ‘NHS family’ (Scottish Executive Health Department (SEDH) 1998a) and wider again as ‘health and social care’ under the new care trusts in The NHS Plan (Department of Health (DH) 2000). These collaborative
arrangements have the capacity to unite health provision across disciplines (integrated working), health sectors (intermediate care) and across agencies (multi-agency working between health, social work and the voluntary sectors), bringing simplified ‘patient journeys’ and move towards the ‘seamless delivery of care’. The duplication of service delivery and thus costs can be reduced and potentially the productivity of the system, and how many clients it can process, increases (Rushmer et al 2003). Service provision can, it has been suggested, be joined-up (Cabinet Office 2000). As well as a strategy for effecting enhanced service provision, legislative changes (SEHD 1998a, 1998b) also identify flatter team-based structures in the NHS as a way of creating the involvement, empowerment and participation of all staff.

The difficulties in effective teamworking in the NHS

However, teamworking seems to have been easier to effect in name than in practice. The NHS Plan claims that the NHS is a ‘1940s system operating in a 21st-century world’. This failure in the system of healthcare provision is claimed to rest, partly, on the ‘old-fashioned demarcations between staff and barriers between services.’ (DH 2000). So serious is poor teamworking felt to be that The NHS Plan lists it as one of the reasons that the NHS has failed to deliver on healthcare priorities in the past (DH 2000).

Such barriers between healthcare staff have been documented extensively (Poulton et al 1993, West 1995). These suggest that although improvements to the delivery of care could be demonstrated in successful primary care teams, such effective performance is almost impossible to foster given the constrains of the work environment namely working patterns, clinical remits and so on (Cant and Killoran 1993, West et al 1995). Other accounts move the focus away from the system, and clearly lay the cause of inter-professional working difficulties at the feet of the staff themselves, pointing to their attitudes and rigid working practices. Ineffective inter-professional working has been said to arise from the poor communication between health professionals (McClure 1984). A term often used to summarise the inter-professional difficulties experienced between healthcare professionals is ‘tribalism’ (Hunter 1996). Similar reasons are cited for the resistance of change in the NHS, where certain powerful groups might lose status or favoured duties.
they are said to resist any changes towards inter-professional working vehemently (Bartkus 1997).

What is repeatedly stated is that new forms of inter-professional working are expected of NHS staff (Scottish Executive Health Department 1999, Homan 2000). Effecting this process rests on establishing of co-operative and collaborative working relationships between health professionals and this is bedrock to the success of the new wave of healthcare reforms. Informally staff are encouraged to blur the boundaries, in order to reduce protectionist, rigid demarcations adversely affecting service provision. Staff are left aware of the need to be more flexible in their approach to working with other professional groups. However, the notion is ill-explored. What might blurring the boundaries actually involve? Does it really offer a way forward in resolving the difficulties experienced by differing health professional in working together? What is unclear is how we can conceptualise what an effective collaborative relationship would be like, what would define it, and how it could be worked to the benefit of staff and patients alike. Is an effective collaborative relationship synonymous with blurred boundaries? This rest of this paper will address these issues.

Moving the debate forwards
The Research Base and Methodology
The ideas in this paper derive from more than a decade of involvement with inter-professional teams in the NHS, working with teams from the primary care and the acute sectors. These teams ranged across health service practitioners and managers and professionals from other agencies (social work and the voluntary organisations). This involvement took three main forms: as an academic representative on project teams; development work and teambuilding initiatives in-situ with ‘live’ healthcare teams and more remotely in the classroom as practitioners undertook further and higher education.

Connate theory
This paper explores the use of diagrams to illustrate the main argument it develops. This is connate theory, in which the way relationships are visually described is inherently linked to the qualities of that relationship.
Connate theory is:

'Visual metaphor which aims to make relationships between people and groups transparent and open to analysis. Complex relationships are rendered visual, so that the way the diagrams look says something about the way the relationship is.'

In this paper Venn diagrams are used to portray aspects of inter-professional working, this does not have to be so. Equally, in other places, other shapes and forms may be more effective in describing different qualities and characteristics of relationships between individuals and groups and the contexts in which they operate. What matters within connate theory is not the precise shape used, but how effectively it shows us the way people interact with each other in order to get something done.

The ideas developed here are based on the way that health professionals work, how health provision is developed and divided between the professional groups and how care is actually delivered at the point of contact with the patient. These ideas and in particular the diagrams (developed below) have been extensively shared and discussed with practitioners and their comments and reflections used to further refine these ideas.

This paper will argue the following main points:

- Effective integrated working through collaborative working relationships and blurring-the-boundaries are completely opposite processes and the terms should not be used interchangeably.
- Integrated working can be thought of and used as a template for the successful achievement of inter-professional working, whereas blurred boundaries bring only ambiguity and confusion, with the potential to lead to resentment and distrust.
- The difference between integrated working and blurred boundaries exists in the establishment and maintenance of clear boundaries between the collaborating partners. These clear boundaries are central to the process of integrated working.
- The boundaries must be negotiated and agreed, specific, respectful and open to review. Work tasks can be shared if there is recognition of commonality in expertise or purpose, together with respect for areas that remain distinct and are not open to be shared.
The Individual (after Rushmer et al 2003)
The health professional (A) appears as a circle. The circle gives the person a boundary, it contains and displays everything he or she is – knowledge, skills, attitudes and so on. At the same time, the context is made clear (X) – all those things outside the person (the setting and areas outside his or her expertise – knowledge, skills, and attitudes and so on).

Effective inter-professional working: integrated working vs blurred boundaries
What differentiates integrative working and blurred-boundaries is the extent to which individuals share tasks successfully. In one way these can both be looked on as attempts to teamwork, or work inter-professionally. We turn to integrative working first.

Figure 1. The individual in context

Figure 2. Integrative working (successful inter-professional working: teamwork)
Integrative Working – successful inter-professional working: teamworking (after Rushmer et al 2003)

There are two health professionals (or two groups of health professionals) A and B. Firstly, the area of overlap (Y), it is something that A and B have in common. It may be that part of the work of A is also the work of B (sharing tasks). They might also share skills and knowledge, or attitudes and interests. The more they have in common the greater the area of Y will be. It is this area of overlap that makes integrated working possible, for it contains skills and tasks they can share.

This is not a blurring of boundaries. A’s circle is still intact and so is B’s, they each maintain his or her boundaries, operating within his or her own capacity and limits. In the diagram there is an area of A’s circle that is solely A. This represents his or her unique combination of skills, which B does not share. A should not be frightened of sharing with B because B cannot overwhelm or undermine him or her, because A still maintains this unique area that only he or she holds. This area is not B’s domain. B is respectful of this area and only overlaps with A in the area labelled Y. B does not invade, interfere or attempt to control A’s unique area of expertise. Likewise B keeps his or her unique expertise and contribution (B) and A is respectful of that. The area of overlap (Y) is clear, has distinct boundaries and this is vital to the success of the overlap, and the ‘health’ of the union. These boundaries are negotiated. There needs to be discussion and agreement between members of the partnership. The individuals should take time to clarify who will do what, when and with what resources and support. Such agreements are binding but not rigid, they can be re-opened if necessary as the situation and context change, allowing them to be dynamic and responsive to changing circumstances.

It would be completely misleading to refer to this union, and agreement to work collaboratively as a blurring of the boundaries for its very success depends upon it being exactly the opposite of that. Its pre-requisite is the clarification of the boundaries regarding what tasks to share, (based on common or complementary skills), on what occasions and to what effect, thereby creating a workable area of Y. Another way to understand the area Y is to think of it as the place where synergy occurs. In area Y exists something that could not be achieved by either A or B on their own (synergy); for example, if A is
blue and B is yellow, the area of overlap, Y, (where the ‘new’ exists), would be green. Green cannot be created by blue or yellow alone, it is no longer about achieving alone, or in sequence but about achieving together. Y takes a genuine, creative merging of A and B’s skills, knowledge, experience, and efforts to bring about something beyond their individual capacities.

To understand the difference between successful integrated working and the oft-quoted blurred boundaries, we now turn to consider what happens if boundaries are blurred.

**Figure 3. Blurred boundaries (ineffective inter-professional working: failed teamworking)**

**Blurred Boundaries – ineffective inter-professional working: failed teamworking** (after Rushmer et al 2003)

In this scenario A and B have tried to establish integrated working and share tasks based on common or complementary skills, but they have not been clear about placing parameters around what each will contribute to Y in terms of task allocation, timing, responsibility and so on. Ambiguity is created and misunderstandings can arise.

**The importance of clear boundaries**

If there are no boundaries around this area of overlap several consequences arise. There is a high risk of:

- Role uncertainty and role ambiguity can arise (who should be doing this ‘bit’? Should it be me?).
- Feelings of inequity (I feel they should have done this ‘bit’).
- Stress and anxiety (am I out of my depth here?).
Feeling unprepared (I didn’t know I was going to be doing this now.).

Concerns for the future can also arise (if I am doing this today, what might I have to do tomorrow?)

Feelings of resentment and distrust can build (I really feel dumped on... or, they robbed me of the best part of this job...).

Implications for the task are that neither party is clear about who is doing what. This can result in either duplication of effort, or that some tasks are missed as each party assumes the other is doing it.

When the limits (boundaries) of sharing are ignored, nothing is clear, certainty is lost and the ability of collaborators to prepare realistically for their work together is gone. Working under blurred boundaries there are no controls – sharing can seem more like invasion. Alternatively, blurred boundaries can seem like abdication where one of the parties ends up doing all the work, or all the unpleasant parts of the work. This is not likely to result in synergy, but will rather foster anxiety, stress, poor performance, and feelings of resentment. Instead of trust and confidence being built, they are destroyed.

Crossing boundaries

If successful integrated working requires mutual consent, focus and crispness in the establishment and maintenance of area Y, what happens when these established boundaries are crossed? Firstly crossing boundaries is not the same thing as blurring boundaries. A blurred boundary is imprecision about who does what when, and is detailed above. A crossed boundary (as the name suggests) is the crossing of a boundary that does exist. In everyday life sometimes boundaries are crossed with permission at other times boundaries are violated without consent.

Crossing boundaries with permission

In integrated working (above) boundaries are overlapped with permission and agreement in advance. At other times in the ‘messiness’ of real life situations, boundaries are sometimes crossed unexpectedly, without prior agreement. This may occur for permissible reasons, for example in an emergency – health professionals act as they must, as the task demands. To illustrate this, an emergency situation in an operating theatre might see health
professionals ‘helping-out’ by carrying out tasks not normally their own. However, in these cases staff are aware of the boundaries, and are clear that
the actions they have taken have ‘overstepped-the-(normal)-mark’ and are
exceptional, and check with the other professionals at the end that things are
acceptable. This re-negotiates the boundaries and justifies the breach of the
boundary (Garfinkel 1967).

Crossing boundaries as a violation
Sometimes boundaries are crossed without permission or the sanction of the
situation. This is more like interference, invasion and is disrespectful to and
undermines the person being invaded. B crosses the boundary and invades
A’s unique area of expertise and ‘has gone a step too far’ and then stands
accused of offending, interfering, or being after A’s job, for example. If this
occurs unwittingly, then an apology usually follows as B realises what has
happened and attempts to repair the violation in the relationship. Where it
is done deliberately it can be seen as a clear signal that B does not trust A to
carry out his or her role without very close intrusive supervision.

The usefulness of connate theory and the diagrams
Feedback from healthcare professionals (over a development period of ten
years) suggest the categories and diagrams help to de-personalise highly per-
sonal and often sensitive work relationship issues and encourage participants
to reflect upon practice and helpful and hindering behaviours and attitudes
when undertaking integrated working. This seems to be brought about by
four inter-related processes:
■ Relationships are made visual – everybody can see what is meant.
■ Sensitive personal issues are diffused into structural relationships, Taboo
  subjects become de-personalised and amenable to discussion. Reflection
  focuses upon the process of task delivery rather than personalities.
■ Abstract ideas like ambiguity and role confusion are ‘grounded’ and
  become meaningful in the work context – so discussion can move forwards
  in very practical terms (i.e. what health professional might do, or not do,
  in order to work together more easily on certain tasks).
■ It is easier to see the differences between effective integrated working and

issues in research
blurred boundaries. The role of negotiated and agreed boundaries that place order, structure and predictability over the collaborative partnership is illustrated. The parties can see the importance of taking time to develop the ground rules that will inform their joint working.

Conclusion
It would be wrong to leave the discussion at the level of the individual as contextual features are crucial when health professionals face attempts to integrate their work (for example, the availability of protected development time, Mallory 1993, Bohmer et al 2001). Other influential situational factors might include the quality of communications, for communications can both ease relationships and prove conciliatory or alternatively be defensive and partial (Deutschman 2001). Historical disputes pervade contexts and defensiveness can make staff unwilling to take part in groups looking at new initiatives (Bain 1998). Additionally there are reasons for thinking that not all participants in collaborative relationships will be equally willing to collaborate, or stand in the same power relationships to the other groups (Labour Research Department 1999).

In other words, the area of X (the context), is not neutral in the process of establishing and maintaining collaborative relationships. Context provides the backdrop against which all action is able to take place, it exerts influence and pressure on the circles (people) and ultimately defines their shape (actions and impact). Participants should attend to the boundaries between themselves and others but also be aware of the constraints and opportunities offered to them by their setting.

Individuals, the organisation and potentially the patient have much to gain from greater co-operative healthcare working relationships. Staff can develop wider expertise; gain knowledge of the role and skills of fellow healthcare professionals; contribute actively to new developments; provide cross cover and support (Rushmer et al 2000, Rushmer, et al 2002). Learning to adjust to new ways of working can open health professionals to further change (Mintzberg et al 1998) and willingness to take personal ‘risks’ in sharing and working collaboratively. The organisation ultimately gains increased flexibility in its service provision, brought about by the multi-tasking and
multi-skilling of staff, duplication can be avoided, co-ordination and communications improved (Borril 2000).

Connate theory
Ultimately if the value of the diagrams lie in their ability to reduce the complex and the emotionally sensitive to simple diagrammatic forms, that is also its major weakness. Once the clarity in the integrated relationship is achieved, the complexity of the context should be woven back in. Decisions surrounding the nature of the area Y are profoundly complex, situated and volatile. The area of Y is dynamic and requires constant maintenance work as settings change.

The diagrams and their explanation provide a simple outline, helping practitioners gain clarity over the complexity in inter-professional relationships in order to take action. However, these outlines and should be reviewed and contextually coloured in (Sacks 1972). The impact of the context (X) should be recognised and any potential solution viewed critically and developed in its specific setting.

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References


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