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COLLABORATIVE CARE - A CHALLENGE FOR US ALL

Collaboration between health professionals is essential for high quality clinical outcomes (Chaboyer and Patterson 2001) and now that boundaries between the roles of different health professionals are becoming less clear, effective collaboration is even more important.

Collaboration implies interdependence and relies on mutual respect and understanding of the unique and complementary contribution each professional makes to achieve the desired care outcomes (Makaram 1995).

Relationships in the health care team are not always ideal, however. In particular, nurse-doctor relationships have a long and fraught history, typified by the 'doctor-nurse' game, described first in the 1970s by Stein (1978), and examined in detail since by others (Porter 1991; Sweet and Norman 1995). It appears to be less common now, but the underlying tension between doctors and nurses still remains, predominantly in non-acute areas. In the health care arena, doctors in particular tend to see themselves as the leaders of any team and may insist on their views having precedence.

This is wrong - not as a knee-jerk reaction by a non-physician - but because the literature shows conclusively that the best care is received by patients/clients when the *appropriate* health professional gives the care. When a number of health professionals need to be involved in order that holistic care is provided, then care given by the appropriate professionals *working together as a team, not as individuals*, will be the best (McPherson et al 2001).

It is this teamwork that sometimes falls down. We see it working to perfection during major operations in well-run theatres, during cardiac arrests in accident and emergency departments with skilled personnel, and at emergency forceps deliveries in midwifery-led units where midwives and obstetricians trust each other to fulfil their roles competently. It is this element of trust, underlying good relations and appreciation of each other's role that makes a good team work well. All the energy that in other units/departments goes into 'protecting our role', 'asserting ourselves' or 'promoting our discipline' can be channelled instead into giving the best possible care.

When professions are static, with little change to challenge the *status quo*, it is relatively easy to move outside one's comfort zone and promote good relationships and collaborative working practices with other professions. Such endeavours are effortless when one's self-esteem is high and one's role identity is strong. In times of change, however, as the nursing and midwifery professions worldwide are experiencing at present, it is not so easy.

When change, transition or new developments are perceived to lead to added power for other professionals and a lessening of power for them, nurses' working identity is threatened. This brings out defensive behaviours such as withdrawal from non-essential work, putting down other professionals to raise one's own self-esteem and expressing envy and rivalry of co-workers in one's thoughts and actions (Hornby and Atkins 2000).

Collaborative practice cannot thrive in such an atmosphere, so the first step in improving collaboration is to work to develop good team relations. The hallmarks of collaborative practice are based in good communication and include: mutual trust, respect, use of conflict resolution skills, use of humour, and negotiation (Taylor-Seehafer 1998), and a philosophy that values autonomy, freedom and equality (Henneman 1995).

Given the history of nursing and midwifery oppression, and the continuation of such attitudes through our effective socialisation process, it is sometimes difficult to see how to move forwards to attain that autonomy, mutual respect and equality.

Nursing and midwifery's biggest mistake, worldwide, was to wait around expecting someone else to rescue them from domination. Liberation from oppression cannot be conferred by the oppressor but must be brought about by the oppressed (Freire 1971).

Nursing and midwifery need to take their legitimate place in the health care team, in order that true collaborative practice can exist. It is only then, when we become truly independent, that we will be able to become interdependent with others (Covey 1989). It is time now to set aside differences and to work with our colleagues from all disciplines towards the common goal of quality care, which will provide the necessary shared identity. In so doing, we need to look beyond our self-conscious profession-centered view, without abandoning those aspects of our heritage that we value most.

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