UNIVERSITY OF LEEDS

ASSESSMENT AND LEARNING IN PRACTICE SETTINGS STUDY: 'THERE'S SOMETHING SPECIAL ABOUT MY PROFESSION: EXPLORING INTERPROFESSIONAL ASSESSMENT

REPORT OF THE FINDINGS OF THE ALPS STUDY, 2011

UNIVERSITY OF LEEDS

SCHOOL OF HEALTHCARE

Preface

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ASSESSMENT AND LEARNING IN PRACTICE SETTINGS STUDY: THERE'S SOMETHING SPECIAL ABOUT MY PROFESSION: EXPLORING INTERPROFESSIONAL ASSESSMENT

INTRODUCTION

Interprofessional working and assessment across professions requires collaboration, understanding of a common purpose, pooling of knowledge and expertise and the facilitation of joint decisions based on shared professional perspectives (Barret and Keeping, 2005). If professional identity is important to the success or failure of interprofessional working, then it is reasonable to assume it to also be of significance in interprofessional assessment. Despite policy drivers for interprofessional learning (Department of Health, 2007), professional culture and professional identity have been found to be compromised by this approach (Colyer, 2004). There is little evidence in the literature of the impact of professional identity on Interprofessional assessment.

This Assessment and Learning in Practice Settings (ALPS) [1]study explored what health professionals understood communication, team-working and ethical practice to mean across eight health and social care professions from the University of Leeds; medicine, nursing, dentistry, midwifery, audiology, clinical physiology, diagnostic radiography and social work. The study was funded by the ALPS programme. The ALPS programme is a Centre of Excellence for Teaching and Learning (CETL) and part of a collaborative programme between five Higher Education Institutions of which the University of Leeds is the lead and includes the Universities of Bradford, Huddersfield, Leeds Metropolitan and York St John. The aim of ALPS is to ensure that students graduating from courses in health and social care are fully equipped to perform *confidently* and *competently* at the start of their professional careers. In order to achieve this ALPS has produced generic assessment tools which can be used by several different professions to assess the

[1] *Incorporating sixteen health and social care professions, it was also one of the largest CETLs, spanning 5 Higher Education Institutions (HEIs: the Universities of Leeds, Huddersfield, Bradford and York St John and Leeds Metropolitan Universities) and a number of Strategic Health Authorities, although working most closely with Yorkshire and the Humber NHS. The sixteen health and social care professions involved in ALPS were: audiology, nursing, optometry, midwifery, social work, physiotherapy, dentistry, diagnostic radiography, pharmacy, speech and language and therapy, podiatry, dietetics, clinical physiology, occupational therapy, operating department practice, medicine.

common competencies of communication, team-working and ethical practice. This report provides a summary of the findings from the ALPS study.

STUDY AIMS AND OBJECTIVES

The main objective of this qualitative study was to explore what practitioners understood communication, team-working and ethical practice to mean in their own profession and what they believed these meant to other professions. To this end the study will:

1. Explore how communication, team working and ethical practice are interpreted across the eight professional groups.
2. Examine whether these responses vary across and within these professions.
3. Explore the impact of any similarities or differences between student assessments for each other these professions.

ETHICAL APPROVAL

Ethical approval for this study was provided by the School of Healthcare Ethics Committee for participants who were members of the University. For participants who were NHS staff ethical approval was given by the National Research Ethics Service (NRES), East Yorkshire and North Lincolnshire REC. In addition approval to approach and interview social work practitioners was given by Wakefield District Council.

METHODS

Recruitment of participants

Participants were recruited via contacts known to the research team (or to the contacts approached) due to their involvement with the ALPS programme. None of the participants recruited to the study were known to team members who carried out the interviews. Purposive sampling was employed to provide diversity across gender and length of experience of assessing students: under or over five years.

Participants

A total of sample of 19 professionals were recruited across the eight professions and were interviewed at a time and location of their choice. Most participants were interviewed at their place of work. The table below provides a breakdown of the participants in each profession. Unfortunately difficulties were encountered recruiting dentists and nurses with less than five years experience in the time period allowed for completion of the study in spite of all possible avenues of recruitment being exhausted.

Profession	Experience in years		gender	
	Over 5	Under 5	male	female
audiology	1	1	1	1
Clinical physiology	1	1	1	1
Dentistry	1	1	1	1
nursing	2	1		3
Medicine	2	2	3	1
Midwifery	1	1		2
Diagnostic Radiography	1	1		2
Social work	1	1		2
Totals	10	9	9	10

Even though participants have been given a number as an ID, due to the small sample size (which is common in qualitative studies) there is a risk that participants could be identified (Green and Thorogood 2009). In view of this, the occupations and ID numbers of participants have been used interchangeably and occupations only used when it was essential in the write up of the interviews. ***We respectfully***

ask anyone reading this report to respect the confidentiality of the participants.

Data collection and analysis

Data collection was undertaken using semi-structured interviews. The interview schedule was informed through the literature review and discussions with the research team.

The interviews were conducted at a time and place convenient to the participant and explored practitioners understanding of communication, team-working and ethical practice and their experience and views on the assessment students in practice. The interviews were audio taped and transcribed verbatim. The visual qualitative data processing package QSR NVivo was used for data management.

A modified Framework approach was used for data analysis (Ritchie and Lewis, 2003). A sub-sample of transcripts were separately coded by four members of the research team to develop a coding frame and this was applied flexibly to the remaining transcripts using NVivo. The codes were constantly reviewed by the research fellow as they were applied to the remaining transcripts. Key themes were identified by the research fellow working with assistance from one of the team members and these themes were refined through discussion with the all team members to ensure they captured the meaning of the data within them. Key themes and sub themes were then identified.

KEY FINDING FINDINGS OF LITERATURE REVIEW

Professional Identity and Social IdentityTheory

A small scoping literature review was undertaken for this study. The literature review focused on professional identity, how this impacted on interprofessional working and assessing students across professions using three of the ALPS competencies: communication, teaming working and ethical practice. Several databases (e.g. CINAHL, Social Science Abstracts, Medline 1996-) and key journals (e.g. Journal of Interprofessional Care) and publishers' websites (e.g. Inter Science journals) were searched using key words in different combinations. Whilst there is substantial literature on team-working, communication and ethical practice in health and social care, there is a lack of literature across the eight professions which examine interprofessional assessment of students. The literature review was framed around social identity theory (which was used as a theoretical framework for this study and guided data collection and analysis) in attempt to manage and reduce the literature into a manageable number of papers. Papers which mentioned social identity theory directly or in group or out group or intergroup where included in the review. Some papers were included to support emerging themes and to back up points made in the narrative style write up. A summary of the findings of the literature review are provided below.

Social identity theory was used as a theoretical framework for the study and this guided data collection and analysis. Social identity theory (SIT) is a theory developed by Tajfel and Turner (1979) and is defined as 'the individual's knowledge that he/she belongs to a certain social group together with some emotional and value significance to him/her of the group membership' (Tajfel 1972: 31 cited in Abrams and Hogg 1990). It is designed to show how people develop a sense of membership and belonging to particular groups and 'deals with intergroup relations – that is how people come to see themselves as members of one group/category in comparison with another (out-group), and the consequences of this categorisation, such as ethnocentrism' (Stets and Burke, 2000).

In SIT, categorisation is assigned a central role and involves the process of putting people into categories or labelling them in some way. SIT is said to become

particularly relevant when one of these categories includes oneself (Abrams and Hogg, 1988). Association with a category and/or membership of a group or groups provides individuals with a sense of belonging and social identification (Skevington, 1981). This process of categorisation allows individuals to make sense of the world around them by creating socially meaningful units (Skevington, 1981). This categorisation process involves a search for distinguishing features between categories which separate and define them. According to Hogg and McGarty, (1990 cited in Hotho 2008: 728) social self categorisation is driven by notions of accessibility and 'best fit' in terms of meaningfulness of characteristics, similarities and dissimilarities. These categories are part of a structured society and exist only in relation to other contrasting categories; each has more or less power, prestige, status and so on (Stets and Burke, 2000).

SIT also draws on social comparison theory. This theory asserts that individuals have an upward drive which leads them to compare themselves to others who are slightly better or similar to themselves (Abrams and Hogg, 1990). This comparison usually occurs between 'in-groups' and 'out-groups' and the purpose of this is to clarify social identity and ensure a distinctiveness between groups. The in-group tends to be the group to which an individual belongs and comparison usually involves 'selective accentuation of intergroup differences that favour the in-group' (Abrams and Hogg, 1990). In this way individuals boost their self esteem through maintenance of a positive social identity and the establishment of a positive distinctness associated with the group they belong (Brown, 2000).

Constructing a professional identity as an in group member

Sociological studies have tended to define and differentiate between professions in terms of knowledge, status, level of autonomy, skills and role and length of training required to qualify for a particular profession (Johnson, 1972; Freidson, 1994; Larson, 1977, McDonald, 1995). Couturier *et al*. (2008: 342) asserts that professions such as nursing, social work, psychology and medicine are epistemologically distinct from each other and 'a discipline exists from the moment a set of knowledge comes to be policed by a system of rules, which are applied in the purpose of transforming this knowledge into a body of knowledge'.

The process of developing a 'professional identity' begins when an individual joins a particular profession, for example, nursing, medicine, dentistry or one of the allied health professions such as audiology, radiography or clinical physiology. According to Hotho (2008) 'professional identity is one of the multiple social identities an individual holds'. It is said to develop as an individual become socialised into a particular profession by adopting the values, attitudes, norms, beliefs, stereotypes, ways of thinking and practices associated with and held by members of a particular profession (Colyer, 2004; Hall, 2005; Adams et at., 2006; Baxter and Brumfitt, 2008). This socialisation process into a profession is said to begin early in a professional's career but the strength of identification with a profession develops at different rates within different professions (Adam et.al. 2006). Whilst an individual may belong to other groups which shape identity, often it is the professional group membership 'that is of most significance to an individual's life' (Adam et.al 2006: 56).

Social identity theory aside, there is currently little empirical research which has examined professional identity, particularly in terms of what it means to an individual member of a profession and how individuals describe their identity in the context of a particular profession (Adams et al., 2006). What literature is available tends to focus on medicine and nursing and with limited reference to other professions. In medicine, one study demonstrated how doctors had a strong sense of their disciplinary and professional membership (Hewett et al., 2009). In this study doctors generally referred to themselves and their colleagues within a teaching hospital setting by their speciality and infrequently were actual names used. Speciality department labels such as 'Gastro' were used instead of recording the name or position of the person in gastroenterology (Hewett et al., 2009). Little reference was made to the organisation in which they worked. Interpretations of social identity theory argue that social identity is partly derived from the organisation in which an individual works as well as other affiliations (Currie et al., 2010)

Status is said to play a role shaping identities within SIT. Health and social care has long been characterised by a strong hierarchy (Hall, 2005). Historically medicine (i.e. doctors) has occupied the most established and dominant of the health professions and other professions have been seen as subordinate to it (Hall 2005). The high status occupied by doctors has been seen to influence their identity.

LaTendresse (2000: 54) found that ‘doctors in a hospital setting portrayed a different type of social identity’ than occupations with a lower status to them. Doctors were more inclined to talk about themselves in interviews than other professions (e.g. nurses, social workers and nurse aides) and their identity appeared closely ‘aligned with medicine and the practice of medicine’ (LaTendresse 2000: 55). Ethnicity, race and association with other hospital staff were less critical to doctors than to the other occupations participating in the study.

In contrast to medicine, nursing and other allied professions have faced challenges in establishing position, identity and status (Hall, 2005; Baxter and Brumfitt, 2008). In recent years through the adoption of advanced roles and more responsibility in care settings, nursing has broken away from the image of nurses as doctors’ hand maidens and has moved towards developing a more independent professional identity than was previously held (Allen, 2007; Millward, 1995). Some studies suggest that nursing is characterised by a ‘female culture’ compared with the ‘masculine traits associated with medicine (Degeling *et al*., 2000: 132). Yet at the same time the identity of nursing is created by the existence of medicine: the enactment of ‘being a nurse’ is realised through the ‘concomitant of routine enactment of ‘doctoring’ (Degeling *et al*., 2000). Other studies examining the revaluing of nursing found that the meanings nurses assigned to their identity derived from their in-group membership took two distinct patterns (Millward, 1995). Firstly, a few nurses in the study described their identity in terms of members of a distinctive professional group on a par with medicine and secondly others build their identity around the ‘caring’ trait traditionally associated with nursing representations. The first representation advocated a ‘more technical less humanistic role’ where nursing skills and abilities were equated to medicine. The second representation drew on a more traditional image of nursing emphasising interpersonal skills and patient centred care.

However, Millward (1995) found that the two representations of nursing sometimes drew on each other. By asserting that care was essential to cure nurses demonstrated that their work was on a par with medicine (Millward, 1995). It is interesting to note that gender played a role in which representation in-group members identified with most strongly: males gravitated towards the representation

which placed nursing on a par with medicine and females to the identity linked with caring. This may suggest that in-group identification is also interwined with other identities (e.g. in this case gender) which are influential in terms of how individual members construct an identity through combination of several interpretations (dimensions) to foster an in-group distinctiveness; yet at the same time create a status able to compete with a dominate out-group, in this case medicine. By combining the two representations of nursing 'distinctiveness', whilst at the same time fostering solidarity within the in-group creates a distinctiveness image for nursing which is able to transcend gender issues. However, Carmel (2006) suggests that these differences between medicine and nursing are exaggerated in clinical settings as there are many similarities in what doctors and nurses actually do in practice.

Like medicine nursing represents a range of different specialisms. Out of the different specialisms mental health nursing is said to have had the most difficulty in developing a professional identity (Nolan, 1993 cited in Crawford *et al*., 2008). In this specialism Crawford *et al*. (2008) found that nurses tended to draw on their role and duties to construct an identity. Nurses in this study had a tendency to foreground the client/patient and described concerns about their role not being granted importance or full recognition as a profession (Crawford *et al.*, 2008).

Constructing an identity through comparison

Social identity theory asserts that any identity is relational and comparative and involves the interplay of many influences both micro and macro (Currie *et al*., 2010). In this way identity is actively constructed and reproduced in relation to other groups (in this case other health professions) and influences such as governmental policy and public discourses. Of prominence then in the construction of an identity is the necessity to compare and contrast one's in-group to other out- groups to promote a positive image of the in-group to which an individual's identity is associated. This process of comparison is deemed important in SIT to develop and preserve distinctiveness of the in group. It is what separates one profession from another and thus helps clarify the identity of group members. Moreover, the development of a distinct identity is considered to foster solidarity among in-group members

(Montgomery and Oliver, 2007). Drawing on the work of Hughes (1984), Allen (2007: 42) points out that 'if members of a group have a sufficient sense of identity and solidarity they will also claim a mandate, to define proper conduct with respect to their work activities, for themselves and society at large'.

In SIT this desire to establish a distinctiveness is said to result in discriminatory attitudes being adopted towards the out-groups whilst the in-group is favoured positively. In this way individuals boost their self esteem and derive a sense of self through this positive affiliation with the in-group. Roccas and Schwartz (1993) posit that the level of in-group favouritism does not automatically result in negative discrimination towards the out-group. The level of negativity may be dictated by the importance the in-group places on certain characteristics or dimensions within their in-group. It follows then that on dimensions of little importance to the in-group which do not pose any threat to their distinctiveness or superiority, no hostility or negativity may be levelled at the out-group.

Indeed, studies have demonstrated that out-group favouritism can occur on dimensions unimportant to the in-group (Roccas and Schwartz, 1993). To explain this, Wider (1986 cited in Roccas and Schwartz, 1993) suggested the 'norm of fairness' which 'motivates people to compensate in-group favouritism on important dimensions by out-group favouritism on unimportant dimensions if there is no cause to discriminate against the out-group' (Roccas and Schwartz, 1993:584). In interprofessional working the fairness norm might become 'working for the best interest of the patient' and therefore encourage professionals to recognise the value of out-group members in working towards the goal of effective health care delivery.

There is evidence from the literature that this comparison occurs within professions and between different professions and the in-group favouritism does not necessarily lead to absolute out-group discrimination. Moir and Abraham (1996) found that student psychiatric nurses would compare themselves to general nurses in order to produce a positive image of psychiatric nursing and differentiate it from general nursing. Although the nursing profession in general was portrayed as enhancing a positive self image, when it came to justifying their decision to choose psychiatric nursing a negative image of general nursing was adopted. Similarly midwives

separated themselves from the nursing profession by asserting the philosophical differences in their approach to caring for women in labour.

Frequently this comparative behaviour manifests itself through the stereotyping of other professional groups. Stereotyping refers to the images, both positive and negative, professionals hold of themselves and other professionals and frequently involves assessment of the skills, knowledge, beliefs, policies, attitudes and other traits perceived to be present within other professions. According to Pecukonis *et al*. (2008: 422) the purpose of stereotyping is to preserve the culture of the group; it is a way in which individuals 'manage group culture by both constructing reality and solidifying perceptions of self-concept'. This process of stereotyping other professions begin early in an individual's career and can be both reduced and reinforced by interprofessional learning (Carpenter, 1995; Barnes *et al*., 2000).

Although only a small amount of literature investigates the professions allied to medicine (Mandy *et al*., 2004), the existence of stereotyping in medicine and nursing is well documented. Carpenter (1995) found that stereotyping occurred between medical students and nurses both within and across these two professions. A range of negative and positive stereotypes were held by each profession of themselves and the other profession. Doctors were described as 'confident', 'caring' and 'dedicated' yet 'arrogant' by medical students and nurses described themselves as caring, dedicated and good communicators. When these traits were applied across the two professions (across the out-groups) differences occurred in how strongly they were applied. For instance, the stereotypes 'arrogant', 'confident' and 'detached' were applied more strongly to doctors by the nurses and nurses were stereotyped more strongly as 'caring' and 'good communicators' by doctors (Carpenter, 1995). Other studies have focused on how professionals rate each other on various characteristics. Hean *et al*. (2006) studied perceptions of health care students from ten different professions; the professions were rated differently on 9 characteristics (academic ability, professional competence, interpersonal, skills, leadership, work independently, team player, decision making, practical skills and confidence). Students clearly associated certain characteristics with particular professions. For example, midwives, social workers and nurses were strongly rated

on their team working and interpersonal skills whereas pharmacists and doctors were highly rated on their academic ability (Hean *et al*., 2006).

Impact of professional identity on interprofessional working and assessing students

The outcome of this behaviour is the development of a distinctive culture and ways of thinking which dominate each profession. In an attempt to preserve and protect the unique distinctiveness that characterises each profession, professional boundaries are created (Montgomery and Oliver, 2007; Hotho, 2008). When professionals come together in teams this distinctiveness has the potential to impact upon team working, communication and ethical practice. In the next section how professional identity may impact on three of the ALPS competences, team-working, communication and ethical practice are discussed.

Team working

Effective team working is said to include a shared purpose, a common goal or outcome, agreed standard of performance and competent members (see e.g. Gilbert *et al*., 2000; Molyneux, 2001; Grice, 2006; Wakefield, 2006; Xyrichis and Lowton, 2008). Cott (1998) found that members of different professions did indeed have different understandings of team working which led to them engaging in different kinds of teamwork. Participants in the study were drawn from a range of professions including medicine, nursing, social work, physiotherapy, occupational and speech and language therapy. Whilst all participants saw team membership as helping them to get their work done, they differed in how they viewed the function of the team to achieve this. Status and role understanding played a part in these perceptions. For instance, Cott (1998) found that staff who occupied low status and had task orientated roles took a ritualistic view of team work which reflected their lack of opportunity to interact and influence other team members. On the other hand, participants occupying the higher status positions were engaged in decision making and problem solving and had a more organic view of team work.

Other studies have identified different understandings of the role individuals should adopt in team work (Clark, 1997; Hall, 2005). Freeman *et al.*, (2000 cited in

Sheeham *et al*., 2007) identified 3 different understandings: directive, integrative and elective. The directive approach was taken up mostly by members of the medical profession who generally saw their role as team leader whereas professionals such as social workers and nurses favoured the integrative approach which emphasised collaborative care and team player. On the other hand, mental health workers leaned towards the elective approach which emphasised a system of liaison, limited communication and independent working (Sheeham, 2000).

It is tempting here to suggest that vying for status among in-group and out-groups and the current position held by each profession as asserted by social identity theory is influential in the approach adopted. There is evidence in the literature to support this notion that vying for status is influential in team working and is responsible for creating tension between professionals. Apker *et al*., (2005) found that perceived lower status of nurses and the way in which they tended to view doctors as their superiors created tension between them. Nurses were inclined to find strategies such as negotiation to ensure their preferred delivery of patient care was adopted when working with doctors. Similarly Moran *et al*., (2007) found that social workers felt marginalised when working in team with other professionals. This marginalisation was experienced in several ways: some participants blamed the predominance of other profession's model of working (medical dominance) and the presence of strong hierarchies. Others cited the differences in understanding of approaches to supporting families and/or disabled people such as the social model of disability. In spite of these differences social workers remained committed to developing new ways of working to enhance multi agency working. However, status did not play any significant role in the tension between midwives, nurses and doctors when caring for women in labour and maternity care. Differences in philosophic approaches to maternity care and the management of women in labour were found to account for the tension (Powell and Lyndon, 2008).

The emphasis on in-group and out-groups vying for status in teams tends to overlook the recognition by health professions of the benefits of team working on delivery of effective patient care. Heath professionals are able to recognise the benefits of team working (e.g. Pullen 2008; Rice *et al*., 2010) and are willing to concede to the superiority of out-group members in terms of their skills and knowledge (Barnes *et*

al., 2000). Members of mental health teams (social workers, nurses, occupational therapists, psychologists and psychiatrists) would rate their own profession highly on certain attributes; they were willing to concede superiority on some attributes to other professionals such as different knowledge and skills Barnes *et al*., 2000). It is accepted in social identity theory that individuals will belong to many 'in-groups' and in the case of health professionals team membership may represent another 'in group' membership where solidarity is achieved through the goal of providing effective patient care. Conceding some superiority to other out-group members demonstrates that professionals are able to acknowledge the existence of differing knowledge and skills in other out-group members when brought together in teams. Moreover, this indicates that positive in-group identification is not confined to members of the profession an individual belongs, but, may reflect a sense of solidarity fostered through membership of a team where 'in group' and 'out-group' members are brought together to work towards a common goal. Acknowledging the knowledge and skills of others implies that each team member's contribution is equality valued (Wakefield *et al*., 2006; Atwal and Caldwell, 2006; Xyrichis and Lowton, 2008). Indeed other commentators have found that a lack of acknowledging the knowledge, skills and contribution of team members is essential in promoting positive team work (Moran *et al*., 2007; Baxter and Brumfitt, 2008).

Whilst differing philosophies may hamper team work, at the same time having a strong professional identity is essential if health professionals are to feel sufficiently confident in their own professional role within a team (Molyneux, 2001; Davies, 2002; Mandy, 2006; Wakefield *et al*., 2006: Moran *et al*., 2007; Suter *et al*., 2009). It serves to allow professionals to feel safe to share and relinquish some of their professional autonomy which in turn promotes more effective team working (Laider, 1991 cited in Molyneux, 2001; Baxter and Brumfitt, 2008). Without a strong identity and clear role within a team, professionals can feel that their professional identity is under threat and not respected by others in the team (Wakefield *et al*., 2006; Moran *et al,* 2007). Moreover they can be left feeling confused about their role in the team (Baxter and Brumfitt, 2008).

Communication

Effective communication between team members is regarded as an essential element of team working and indeed recognised as an essential competency within professions (Shakespeare and Webb, 2008). Again the literature tends to focus on interaction between health professionals and/or patients and its effectiveness rather than what they understand communication to mean across professions. Newson (2010: 366) defines communication as 'the exchange of information between sender and receiver' and can be divided into verbal and non verbal skills. Professional identity and its inherent status have been found to influence communication between professionals. Professionals in lower status professions can be reluctant to voice their opinions in teams where higher status professionals are present (Gardezi, 2009). This reluctance to articulate was interpreted as a 'protective' silence. Nurses in the operating theatre were concerned that speaking out might result in being reprimanded for not knowing the surgeon's preferences and thus demonstrated how power and status impacts on communication between doctors and nurses (Gardezi 2009). To overcome these hierarchical barriers, nurses tend to employ indirect forms of communication when interacting with doctors. Propp *et al*. (2005) found that nurses would process and deliver information to physicians in ways which adhered to the individual needs and preferences of physicians. This involved presenting accurate and sufficient information in a form useable to physicians to enhance better patient outcomes. Nurses filtered out unnecessary information and used focused messages which incorporated the preferences of individual physicians. Although nurses were expected to participate in shared decision making, hierarchical considerations affected their level of participation and the way in which they communicated their opinions,using assertive and diplomatic strategies. The latter concealed the extent to which they were providing solutions to problems; examples of this way of communicating included acting in a submissive manner towards physicians and by allowing them to think that ideas put forward by nurses were actually the physicians (Propp *et al*., 2005).

Similarly, Apker *et al.,* (2005) found several strategies employed by nurses to influence doctors and override differing philosophical approaches towards patient care. The tension between professionals in this study was centred on the changing

roles of nurses which required them to adopt a more decision making role. The strategies employed by nurses in this study appeared to be influenced by the strength their identity and how equal they felt in status to physicians. Some of the strategies identified included 'accommodating the hierarchy, denying the hierarchy and softening the hierarchy' (Apker *et al*., 2005). Accommodating the hierarchy involved indirect forms of communication which masked their input. Softening the hierarchy saw nurses attempting to communicate as equals whereas denying the hierarchy involved nurses challenging the hierarchy to advocate for patients.

There is also evidence that in-group members tend to favour communication with other in-group members. Grice *et al*., (2006) found that employees in a public hospital rated communication with their own occupational groups more than communication with team members who were identified as members of the out-group. That is belonging to other occupational groups.

Ethical practice

In the context of ethics it is suggested that the understanding of ethical issues between team members will differ. Clark *et al.,* (2007) see interprofessional ethics as an emerging field of research and referred to ethical issues as functioning at an individual and collective level. At an individual level ethical understanding is reflective of professional education and personal background whereas at a collective level it is influenced by professional codes of conduct which lay out the responsibility of providers (Clark *et al.,* 2007). Clark *et al.,* (2007) emphasises the importance of establishing an ethical framework by which team members can be integrated into interprofessional teams through sharing of professional values and different understandings of ethical approaches. In a small case study of 4 health and social care professionals they asserted that application of this framework stimulated discussion between professionals and allowed differences to be identified. Other studies have shown that professional differences can led to different ethical approaches being taken towards patients care. Whilst stating that these differences are small Carmel (2006) found that nurses working in an intensive care setting took a relational view of the patients whereas doctors had a tendency to objective patients. Similarly, Melia (2001) in a similar setting found that differences of opinion would

arise over decisions to withdraw treatment between doctors and nurses which were related to different philosophical view points. However, like Carmel (2006) on closer inspection these differences could be explained in part by the proximity of the professional to the patient. Other commentators have suggested that ethical conflict can arise between individuals from different professions because of the characteristics associated with professional identity such as culture, language, professional boundaries and in-group competition (Irvine *et al* 2002).

Assessing students across professions

The above issues identified by social identity theory which are seen to affect teamwork, communication and ethical practice between professions will have to be put aside when assessing students across professions. Professional identity and hierarchical consideration have the potential to influence expectations of students by assessors. Professionals are likely to bring differences and similarities associated with their own profession's identity to the assessment of students in practice. In the literature the attitudes of mentors have been shown to affect the learning environment and assessment of students (Webb and Shakespeare, 2008). According to Fitzgerald *et al*., (2010) the literature on how professional values affect assessments of competences is limited. What literature exists demonstrates that professional identity impacts on interprofessional mentoring and assessment of students across professions in practice. Marshall and Gordon (2010) identified issues affecting interprofessional assessment across health professions in a study involving professionals from several disciplines including medicine, nursing, social workers, occupational therapists, paramedics and dieticians. Differences noted between professions related professional identity and expectations of each profession. Professionals expressed uncertainty about whether they had the required knowledge necessary to assessment students from other professions. This uncertainty referred to a lack of knowledge about the purpose of the student's learning which arose out of concerns about limited knowledge of the subject specific curriculums of other professions (Marshall and Gordon, 2007). However, some practitioners were able to accept some boundary blurring and that there were generic skills which were applicable across all professions. When this way of thinking occurred then practitioners were able to focus on the generic parts of an

assessment without worrying unnecessarily about subject specific curricula (Marshall and Gordon 2007).

KEY FINDINGS FROM THE INTERVIEWS

The meaning of communication, team-working and ethical practice

Participants were asked what they understood communication skills, team-working skills and ethical practice to mean. Participants appeared comfortable describing what they understood communication to mean, but were less able to describe team-working and ethical practice. Most participants responded by explaining what they did in practice rather than describing what they believed communication, team-working and ethical practice to mean. Thus the majority of participants conceptualised these three competencies in functional terms.

Communication: 'conveying information'

A key theme which appeared to capture the meaning of communication for most participants was 'conveying information' to other people whether directly or indirectly. For the majority of participants conveying information had a functional purpose which was to 'get the message' across to both students and patients to 'building understanding' about what was expected of them during procedures or how they should carry out specific tasks or procedures.

> *It's an effective way of getting information through to people, making sure they can understand (12)*

> *Well it's being able to portray what you want somebody to do in a manner that they can interpret and understand (03).*

Several participants described communication as a 'two way process' and involved the exchange of information from receiver to sender and vice versa (09, 19).

> *It includes that (conveying meaning) but it will also include listing information, trying to understand what's happening to a person and interpretation of that. Some of its receiving information and some of it is then giving information back…(09).*

In this way communication was also about building a mutual understanding so each person involved in any discussion would be understood what was being said in a similar way whether it was by students or patients and their families. Important to

this ‘two way process’ were listening skills and posing questions to check meanings and clarify interpretation.

Many participants listed a range of ‘skills’ they considered were important to ‘conveying information’. These were broken down into verbal and non verbal skills and were seen as essential in promoting effective communication between health professionals and patients and putting the patient at ease when appropriate. Verbal skills were some times described as ‘oral skills’ and included the ability to interact effectively to a range of different audiences by adapting language and terminology accordingly.

> *(Communicating) on a level that they can interpret so it’s about interacting with people on different levels in a way, making phrases and terminology for which they can understand (03).*

Non verbal skills such as body language and written skills were included in descriptions about communication. The way a professional positioned themselves with a patient and the use of eye contact had the potential to convey that they were listening to the patient or student to whom they were talking.

> *It’s not purely verbal it is how you interact with your patient…..eye contact, the way you lean towards somebody. A lot is body language (03).*

Team-working: ‘working together’

Participants were asked what the term ‘team-working skills’ meant to them and a key theme ‘working together’ emerged. For the majority of participants ‘working together’ again had a functional purpose and was about working towards the fulfilment of a ‘common goal’ which referred to delivering effective care to patients (e.g. 05, 03, 06, 07, 10, 11,14).

> *I think to me it means working with a group of people, formally that would be but what would be in my head is working with a group of people to achieve a specific outcome…. (04)*

Other participants conceptualised the meaning of team-work in terms of ‘sharing the burden’ of work load through engaging the support of colleagues within their own

profession and across professions (07, 03, 10, 13). Others saw it has a way of 'pooling expertise' through the specific contributions of different team members. This referred to both sharing knowledge and the utilisation of team members' strengths and weaknesses (05, 06, 10, 13, 14).

Ethical practice: 'being professional'

Many participants struggled to articulate a meaning for ethical practice and tended to describe it in functional terms. Only one participant, a midwife, conceptualised ethical practice with reference to some of the ethical principles associated with health and social care: beneficence, non-maleficence and justice. Whilst other participants did not directly refer to these principles their descriptions of ethical practice clearly alluded to them indirectly. For instance, several participants talked about working morally, doing no harm and being honest and trustworthy. 'Being professional' was the key theme which appeared to capture the meaning participants applied to ethical practice. This 'being professional' had several dimensions to it and included; considering with patients and working as a professional.

> *Behaving honourably towards patients and colleagues, being concerned to ensure I do the best and that others are doing their best. The patient is our first concern and together we have to….must be our brother's keeper to sometimes challenge each other if things are happening that aren't in the patient's best interest (09)*

Considering Patients

Many participants conceptualised ethical practice in terms of their responsibility not to do harm to patients. For many participants this was described in terms of maintaining confidentiality, respecting patient's dignity when carrying out procedures and examinations, observing diversity and treating all patients equally irrespective of age, gender and culture. Working in a 'non judgemental' way, which meant keeping their own values and opinions to themselves whilst working with patients, was also conceptualised as part of working ethically. This way of working was stated to protect patients' wellbeing during the delivery of care.

I don't want to go into the law but it would have to do with acknowledging my own personal views and how they may affect my practice (13).

Protecting the wellbeing of patient and thus doing no harm to them through keeping secret the information they disclosed was conceptualised by some participants in terms of maintaining confidentiality. Maintaining confidentiality for many participants played a significant role in ethical practice but was an element which created many dilemmas and was difficult to define in absolute terms. Using confidentiality to illustrate their point, two participants discussed the conflicting and complex nature of ethical practice. It was questioned whether patients understood the nature of confidentiality in health and social care and were aware of the amount of information shared between professionals. Thus in sharing information to benefit a patient, they risked doing harm if patients were not aware of the extent to which information may be shared between professionals.

And I mean I know there's massive arguments about whether confidentiality in healthcare really exists because everybody knows what's going on…(19)

The latter was discussed within the context of team-working and with reference to cleaning staff and healthcare assistants who did not have codes of conduct and would discuss patients among themselves.

Working as a professional

For many participants the meaning of 'working professionally' involved maintaining professional standards of behaviour laid out in code of conduct set by their own profession (04, 02, 05). This included behaving in an acceptable way in practice towards patients and fellow professionals and was defined as 'professionalism' by a few participants (04). One participant highlighted the importance of maintain this professionalism both inside and outside work (05). Behaving badly outside work was perceived to reflect negatively on professions. In constructing this meaning of ethical practice, several participants drew on perceived societal expectations of professional behaviour and a discourse of 'wrong' and 'right' behaviour (02). For some participants this included policing their own profession by 'whistling blowing' and

behaving in a manner which conveyed honesty and trustworthiness towards patients and fellow professionals (03).

> *Well that could be whistle blowing; it could be, you know, if they've actually has something done wrong to them, or maybe if somebody is not maintaining their confidentiality, things like that as I say to protect them (03)*

Professional differences across professions

There appeared to be a consensus across the eight professions about how communication skills, team-working and ethical practice were understood. The differences which surfaced appeared to relate more to the ability of the practitioner to articulate their understanding. At first glance it is tempting to suggest this is related to the level and length of education of doctors. For example, one participant, a doctor, gave a more elaborate description of team-working as representing 'a complex set of interactions between individuals put together to achieve a set objective'. However, this description did not differ in content to other participants who used less elaborate language and described team working as 'a group of people working together to achieve a common goal'. Overall, participants' understanding of communication, team-working and ethical practice differs little across the eight professions and common themes arose.

Assessing students

Participants were asked how they assessed their own students. Most participants stated that they assessed students informally through observation and successful completion of tasks in practice settings rather than under examination conditions. This applied across all three competencies and across the eight professions with the exception of one doctor who referred to formalised assessments of medical students, particularly their professionalism (04). It also appeared that participants relied on their 'gut instincts' to judge the performance of students and had clear expectations of what was expected from students in their profession.

Communication: What assessors looked for: 'ability to interact with patients'

Participants were also asked what they 'looked for' when assessing their students' communication skills. There was a general consensus across the eight professions about what was important to look for, and occupying all participants' accounts was how their students interacted with patients. Central to these accounts was the well being, safety and comfort of patients and effective interaction was seen as an essential tool for putting patients at their ease and ensuring a 'safe' transition through the health and social care system. It was recognised by many participants that attending hospital could be a stressful and anxiety provoking experience, especially in acute situations.

> *From greeting the patient, you know, they communicate verbally, there's being able to get the patient to relax and it's all about the way they act with the patient (12)*

Effective interaction with patients was measured by how well students utilised many interpersonal skills, verbal and non verbal, which participants identified as essential to be effective.

> *I would say a mixture of everything that we've talked about really, you know the verbal, the non verbal, the eye contact and, you know, actually body language, how they actually sit, where they sit when they're talking to families, see what empathy they show (10)*

Many of these skills were seen as interdependent and thus could not be examined in isolation. There was sometimes an overlap with ethical practice since the attitude of the student could be conveyed through the language they used and the tone of voice they adopted.

> *And then I would go on to look at how they talk, how they address people, how they respond to what other people say and how the people act towards them(02).*

Ability to listen to patients (listening skills)

A student's ability to listen to patients was identified as essential to establishing a rapport with patients since students' needed to hear what patients were saying in order to 'pick out the salient points' in a discussion in order to get the 'whole story from patients'. Listening to patients also included reading their body language which could convey non verbal cues.

> *They need an ability to listen (01)*
>
> *That's an important element of communication. And again you can pick up from how they're sort of interacting with the person as to how much they are actually listening to them (14)*

Ability to convey appropriate body language

For many participants body language was an important way of conveying to patients that they were being listened to, and a means of expressing empathy through, for example, nodding of the head and eye contact. How students' positioned themselves with the patient was also flagged up as important.

> *Well whether they're facing the patient…whether there's eye contact, you know, just how they're sat, little things like that, the positioning in the surgery (03)*

Ability to give and probe for sufficient information

Being able to elicit appropriate and sufficient information from patients was regarded as essential. It was seen as essential for the well being of patients and examples given highlighted patient safety such as finding out if a patient was pregnant prior to an x-ray being undertaken (07).

> *We always make sure that they're said enough to cover everything that they actually need to know….we have to ask the women the last date of their period to make sure they're not pregnant, those kinds of things have to be done before they press that button and expose them (to radiation) (07)*

The ability to use appropriate language and adapt language to patient's level of understanding

Many participants were keen to emphasise the importance of spoken language. This had several dimensions to it and included avoiding swearing, not using jargon whenever possible, selecting the appropriate words when giving results, breaking bad news and addressing patients (09, 13).

> *You've definitely got to…it's got to be appropriate to who you're speaking to. I don't think we can be calling people love and things like that I think the language you use has got to be appropriate (06)*

Another important dimension included the ability of the student to adapt their communication to a range of patients from different backgrounds and cultures or patients who may use different types of communication such as lip reading or whose first language was not English. Speaking clearly and concisely was flagged up in particular by audiologist who considered this an essential skill because of their job involved dealing with patient with impaired hearing who may lip read.

> *On a simple level whether they use medical jargon. And I know that's very simplistic because you do use medical jargon, but as long as they back it up with explanations (04).*

Ability to use written skills effectively

These were also seen as essential for communicating information in to other professionals and writing up patients' notes.

> *Written language we tend to write reports so that comes into play with the reports, they need to again be clear and to the point. So we look at that as well (12).*

Ability to convey appropriate attitude

Whilst attitude was linked to ethical practice, participants flagged up the importance of students communicating an appropriate level of friendliness to patients through

both verbal and non verbal skills. Several participants felt students needed to strike a balance between maintaining a professional distance from the patients and engaging with them in a 'friendly' manner.

Team-working skills: 'ability to work with others'

There was some overlap in what participants looked for when assessing their students' team working skills. For example, the student's ability to communicate effectively was seen as essential to good team-working but here the emphasis in the communication section had been on patients, the focus in this section moved to interaction with colleagues. Again participants describe a list of skills they considered important to 'good' team-working.

Ability to know their role and boundaries

Many participants spoke about the importance of students *knowing their role* in the team in terms of what tasks and skills they were expected to have and contribute in their profession (01, 12, 02, 04, 12, 03). This also included students being able to recognise their own limitations and the boundaries associated with their professional role. For some participants this drew on the unqualified status of the student and expectations that they should keep to the role and only take on the responsibilities outlined in their student logbooks. (11, 14, 15).

> *To me being able to take on board what somebody else is thinking and seeing it from their point of view because there's always different sides and different perspectives to everybody's situation (03).*

Ability to seek advice

Linked to the student's ability to know their role and boundaries was the ability or willingness to seek advice. This was regarded as important in terms of the student recognising their own limitations and essential to the development of the student. Linked to seeking advice was the students' ability to take on advice from others including constructive feedback from colleagues (12, 05, 08, 11, 13, 14).

> *I would expect them to be able to sort of look towards the team as well, you know, for advice and to be able to ask questions (10)*

In the respect that if you're not sure about something, instead of keeping it to yourself and not knowing what to do, go to somebody else and ask them for advice (15).

Ability to communicate with colleagues

Again this awareness that compromises may have to be made and teams would comprise of a range of professionals, the importance of students demonstrating effective communication skills and negotiation skills was stressed by some participants (02, 03, 04, 05, 12). These were seen as important in terms of resolving any conflicts that might arise over ways of working or decisions made about patient care. Communication skills were also stressed in the context of co-operation with others (see 02).

I would say that was a key, effective communication skills because effective communication skills you don't get the friction and the confrontation…..(03)

Ability to be pro-active and contribute to team decisions

Many participants were concerned with the ability of the student to recognise when they were required to 'pitch in', not just with their own ideas but in practical terms when, for example, a colleague required assistance. Many participants expected students to be proactive and pitch in both in terms of their own ideas and when colleagues need support with, for example, completing a task or keeping a clinic running on time (e.g. 07, 03, 06, 10, 11, 13, 14).

Although I've said our role is mainly monitoring there are occasions where we do have to get involved hands on in a case. And if a student was mainly sat at their post reluctant to go and help then obviously that would be a big problem (12).

Whilst many participants had expectations that students should 'pitch in' or 'muck in', there was awareness that a reluctance to contribute might reflect a lack of confidence on the part of the student when working in a clinical setting or when facing a new situation. In contrast some participants mentioned that some students could be over confident believing that their profession was 'the be all and end all' and

thus had a tendency to view other professions as being below their own profession. This tendency to view other professions as of lower status might be reflective of the working environment in which the students were working or had worked and their attitude might alter in environment were higher status professions were present or once they had gained more experience.

> *I think some of them are over confident. Some students are over confident. I've worked with a couple of students that don't respect other professionals and think nursing is the be all and end all and other professions are a bit down in the pecking order (06)*

The expectation that students pitched in also included contributing to decision making. Students further on in their training were expected to contribute more to decision making than those at the start of their careers. Thus some participants stated that ability to make decisions or contribute to them was not assessed as closely in the early stage of a students' career (14).

Ethical practice: 'ability to maintain professional standards'

Describing what they looked for in students when assessing ethical practice appeared to be complicated by a recognition that ethical practice itself was a complex area and thus difficult to assess. It was also complicated by the participants concerned that they were merely repeating what they had said earlier, about communication and team-working. Most participants were keen to emphasise that working ethically was about demonstrating professionalism and their expectation of students' ethical practice tended to mirror their own understanding of 'being professional'. Thus the student's 'ability to maintain professional standards' emerged as a theme. When talking about maintaining professional standards participants drew on codes of professional conduct, their own understanding of ethical practice and, a few, on their own experiences of being a patient.

Ability to demonstrate etiquette

This referred to the appearance of students which occupied several participants' accounts. Dressing both appropriately and taking care over their appearance was seen as communicating professionalism to patients. Some participants saw dressing

appropriately (e.g. not wearing revealing clothes or wearing a tie) essential where students would be dealing with patients from different cultures where dress played a large role in religious beliefs. Demonstrating etiquette also extended to include avoiding inappropriate behaviour such as swearing in the presence of patients, time keeping and addressing patients by their chosen title or name. It was mentioned that some older people preferred being addressed as Mr or Mrs rather than their first name (15).

> *We look for professionalism and again it's how they speak to patients, isn't it. But sort of going on from there professionalism… we look at their attendance and if they're coming in late a lot or they leave early or they take longer for their lunch, whether they dress okay, whether they've go their badges on, they've got their jewellery off (01).*

Ability to maintain confidentiality

The student's ability to maintain confidentiality was of paramount importance to all participants' accounts. Students were expected to maintain confidentiality at all times both whilst at work and in their private lives (01, 12, 04, 07,). Thus students were expected not to discuss patients in public settings for example whilst travelling on buses and on social networking sites, such as, Facebook. This was important not just for the wellbeing of patients but to fulfil legal requirements and adhere to professional codes of conduct.

> *Confidentiality is extremely important like data protection thing. You know, anything about that patient must not be discussed outside the hospital or even inside the hospital unless it's relevant (01).*

> *Not discussing (patients) on Facebook is a big one that's in now, or anything that does not need to be discussed not really naming people (07).*

Whilst there was great emphasis on students' ability to respect confidentiality at the same time students were expected to recognise when information might need to be shared and the dilemmas that might accompany it.

Ability to respect patients

This subtheme covered both patients and colleagues. Respecting patients was multi-dimensional and was about observing of range of patients' rights including; their right to autonomy, inclusion in decisions; right to consent to treatment; right to information and respect for their dignity and privacy (01, 12, 03, 04, 06, 07, 08, 09, 10, 13, 14, 15, 16, 19).

> *It's sort of how the student deals with the patient, you know, are they polite with the patients, do they listen to them, do they respect the patient's view, do they give them you know all the treatment options, they're not coercing them into certain treatment paths (05)*

When applied to colleagues respect was about recognising the different roles or ways of working of other colleagues. Reference was made to the ability of students to recognise the role and contribution made by others in their working environments (01, 12, 02, 05, 07, 09, 11, 13, 14, 15). Similarly students were encouraged to work with and observe a range of team members to experience different ways of working. This was considered important to develop the ability of students to take on other people's perspectives (02, 03, 04, 06, 09).

Ability to work in a non judgemental way

Working in a non judgemental way was brought up by several participants across a range of professions against a background of ensuring equality and fairness. This referred working with patients according to their needs rather than what or who they were. Social workers emphasised the importance of 'evidence based' reports and accuracy in conveying factual information without the inclusion of 'sweeping statements' based on the assumptions of students and qualified professionals (10). Keeping their own views and opinions to themselves in challenging situations and when working with patients from a range of different backgrounds, cultures and lifestyle choices was seen as essential to working non-judgementally.

> *Again sort of not to be judgemental…..it's one of the skills if you like that you're got to learn, and it is one of your values (10).*

It means regardless of your race, religion, colour, anything, put them things aside, you're dealing with a patient as a patient and you're not going to judge them or be stereotypical or anything just because of the way they are….(15).

In this section there appeared to be few differences in what participants looked for or expected from their students in practice. Some differences were noted in the emphasis some participants placed on certain skills. For instance, doctors were keen to emphasise the importance of leadership skills whilst nurses and midwives saw greeting patients arriving on wards in a friendly manner essential to their role. Social workers talked about the importance of students working non-judgementally as essential to their role.

Whilst these observations are important, it should be noted that although participants placed some emphasis on some skills it cannot be assumed that other skills given less emphasis during the interview were of less importance to their profession. It might be that participants chose to concentrate on skills they considered important to cover in the time allowed for the interview. However, as will be revealed in the next section when asked about interprofessional assessment professional identity became more apparent.

Assessing students across professions: '*Preserving the distinctiveness'*

When participants were asked for their views on assessing their own students little reference was made to their professional identity or the in-group' to which they belonged. This changed significantly when the focus moved to assessing students across professions and participants seemed keen to preserve the 'distinctiveness' of their own profession. Participants were keen to emphasise the differences they perceived existed between different professions and how the features associated with different professions would hamper assessments across professions. There was consistency across length of experience of assessing students in practice. The differences described by participants are outlined below.

Communication

Different degrees and types of communication

The differences described about communication by many participants across the eight professions revolved around the expectation that other professions would expect different degrees and types of communication from their students.

> *I guess there would be a difference in the fact that you're not assessing like with like with each profession are you. I think each profession is quite different and trying to lump them together in how they communicate I'm not sure how easy that's going to be because there is a lot of differences… (16)*

One participant, a diagnostic radiographer, spoke about how they believed nursing and medicine would require their students to engage in more rapport than in their own profession due the nature of their relationship with patients. It was considered that both nurses and doctors were likely to spend more time with patients than radiographers who were not required to take patient histories or nurse patients on hospital wards.

> *I mean they're going to be professional specific (differences) I suppose. I don't know, I think probably the only one that I could think could be a difference….maybe nursing to a degree because if you're got a nurse who is nursing on the wards they're going to have much more rapport with patients because they're seeing them like day in and day out or whatever.*

Radiographers were contrasted with clinical physiologists who were perceived to require less communication skills (clinical physiologist). Dentistry was singled out by several participants who thought that dentists would not require the same level of communication skills to social workers, nurses, midwives or radiographers. Dentistry was also perceived as requiring less verbal communication skills than other professions but this was not consistent across all participants. For example, some recognised that dentists would also deal with stressed and anxious patients.

Whereas dentistry you're not necessarily spending a lot of time talking to them. So I guess it's going to be different for some of these professions in terms of what they're doing (16)

This perception that some professions would required a more in-depth level of communication to others drew on assumptions about the nature of the role these professions undertook and/or the continuity of the relationship. For example, it was believed that the dentist-patient relationship would not involve much two way communication. Whilst dentists saw themselves as dealing with a specific area of the patient, the mouth and teeth, they did not share this view that their work required different or limited communication skills to other professions. Indeed, they flagged up the importance of 'good' interaction using verbal and non verbal skills to put anxious patients at ease in the same way as other participants.

Social workers brought up the issue of students being able to communicate accurately and factually in written form as well as verbally. This was regarded as critical if communication with other professionals, including those beyond the health and social care environment, were to reflect a client circumstances and situation appropriately whether in case notes or in verbal discussions. Similarly audiologists also drew attention to different types of communication and emphasised lip reading and sign language. These were seen as essential forms of communication for people with impaired hearing and whose first language was not English.

Obviously it's not appropriate with all our patients to have just verbal communication because we have deaf patients, a range of them and everything that goes along with it, I mean lot of our patients don't speak English so kind of pointing at things would count as kind of communication to them and writing things down. But anything that can get the message across of what we're going to do and making sure they're safe and happy (07).

Team-working

Impact of hierarchy

In team-working participants highlighted the issue of hierarchical structures. These were seen to affect expectations of the role students should adopt and the amount of

responsibility when working in teams with members of their own profession and in multi disciplinary teams. For instance, one participant, a doctor, spoke about a 'hierarchy of decision making'. This referred to the way decisions tended to be made from top down with senior staff taking the lead and more junior staff having less input. Whilst it may seem appropriate for senior staff to make decisions, this appeared to translate in practice to the higher status professions having more power whether real or perceived when working in teams. There was evidence that the higher status professions did expect their students to become 'team leaders'.

> *They're encouraged to see themselves as team leader because that's the sort of role they will be expected to take in practice, that's not at the expense of treating other people any less respectfully (05).*

On the one hand this was considered to results in expectations that at the lower end of the hierarchy would be expected to make sure all the 'leg work' was done for more senior staff. Conversely, it was perceived to affect the level of input from students into decision making in different professions. It was believed that proactive interaction from students might be perceived negatively in medicine in comparison to nursing (14). A nurse suggested that a senior doctor on a hospital ward round was more likely to 'look straight towards the qualified nurse' for a response rather than a medical student' (14).

Moreover, it was pointed out that some non medical students could be frightened of doctors and this could affect their interaction with patients and other staff when in the company of doctors (19). Although it was felt that how 'frightened' student from other professions might be of doctors would dependent on the personality of the doctor (19).

The issue of hierarchical structures in health and social care was touched upon across all eight professions and appeared to be an attempt to establish the identity and importance of their profession in relation to others.

Philosophical differences

Some participants talked about how conflict and misunderstandings were a risk when working with professionals from other disciplines. Social workers described

how differences in language, terminology and approaches taken towards clients had the potential to create misunderstandings. It was pointed out that social workers tended to use a social model approach towards, for example, disability issues, whereas other professionals such as general practitioners were more likely to work from a medical model perspective and thus could sum up situations differently to social workers. This view was also shared by nurses who felt some professions were more likely to use a medical model than others such as social workers.

> *So I think probably audiology would be with the medical model, more of the medical model whereas I think the social work thing might be more a similar model to the holistic model that we have (14).*

Other concerns expressed referred to different models of working e.g. a midwife spoke about how they felt there were differences in approaches to patients by doctors, midwives and nurses (19). Doctors were perceived to be more clinically focused and were thus less concerned with whole patient. However, individual personalities of professionals were again noted to affect their working styles and/or approaches to patients (19).

Ethical practice

Nature of the work

In ethical practice the professional specific differences were focused on the nature of the work undertaken by each profession. Many participants believed that beyond core skills the work undertaken by each profession would affect ethical practice. It was believed that what professionals did in their day to day work with patients would influence the ethical decisions and the extent to which they observed the different principles linked to ethical working such as maintaining autonomy, confidentiality, dignity and respect. For example, it was assumed that because dentists may not require their patients to undress to the extent which may be required in other professions the approach and type of consent would differ. Similarly it was believed that the need to protect patients' dignity would be lessened for dentists than in other professions such as medicine, nursing and midwifery where more intrusive procedures would be undertaken. With the latter in mind, the issue of obtaining

consent was seen as more complex in some professions. For instance, obtaining written consent from patients was not seen as a 'big issue' for radiographers or clinical physiologists. Thus for some participants the level of involvement and the more intimate nature of the relationship (e.g. nursing) with patients had implications for ethical practice across professions.

> *I suppose the ethical practice would be the difficult areas…. I think would be very different like I said before I was thinking more of informed consent, the holistic, dignity and privacy and all that sort of stuff (14).*

Ethical dilemmas

There was also a belief that some professions would face 'bigger dilemmas' than others. This assumption drew on both the nature of the work and in the type of relationship other professionals might have with patients. Midwives and nurses were singled out by some participants as also facing more ethical dilemmas than other professions due to their roles: dealing with unborn children and acting as the patients' advocate (14). The latter role was linked to the likelihood of nurses having a closer relationship with patients and thus be privy to more disclosure of information than other professions. It is important to note that the belief in a close relationship with patients with nurses was highlighted by a nurse who was keen to emphasise the nature of nurse –patient relationship judged to be a unique feature of nursing. Moreover, they considered the ability of students to work with a non-judgemental attitude of ultimate importance across many areas of social work because student social workers were likely to find themselves in very challenging situations which would test their own values.

When describing these differences participants compared the requirements of their own professions and those they perceived were relevant to other professions, particularly the work carried out by each. Social identity theory asserts that one purpose of this comparison between in and out- groups is to establish a positive distinctiveness which favours the in-group to which an individual belongs (Abrams and Hogg, 1990). Whilst the majority of the participants were keen to point out the differences between professions and the positive elements of their own profession was not done at the expensive of other professions, the out-groups. It appeared that

most participants recognised the value and input of other professions and the lack of negativity may be explained by an acknowledgement that all health professionals were working towards a shared goal: good patient care. This notion that all participants in the study shared this goal underpinned many of the accounts and may have reduced the negativity argued to occur between in and out groups in social identity theory. Thus the in and out-groups in health and social care become united by this shared goal and see themselves as belonging to another in-group, the health and social care organisation to which they work.

Impact on Interprofessional assessments

Profession specific knowledge and understanding

The majority of participants were keen to acknowledge that communication, team working and ethical practice could be classed as generic competences and could in principle be assessed across professions, they saw the differences they described as barriers to a valid assessment.

> *If the assessment was based purely on team work or communication or ethical practice or something particular like that then I think that wouldn't be a problem (clinical physiologist)*

The reservations participants held about validity of any interprofessional assessment focused on a belief that any assessor would require profession specific knowledge and understanding of the role requirements of specific professions to accurately assess students. Otherwise it was felt that assessors might miss or misunderstand the performance of a student, particularly the emphasis that might be required on different aspects of communication, team-working and ethical practice in the specific profession.

> *Because obviously you need the background and the knowledge base even for the communication stuff don't you, you know…(10).*

It appeared that many participants felt that the differences they perceived existed might result in different expectations from assessor which in turn might also affect the assessment for some students. This was echoed by two other participants who

felt that it would be ‘unfair’ of them to assess students from other professions and vice versa (1, 16).

> *I would think it would be extremely unfair for our students for example to be assessed by a nurse assessor but I would equally think it would be unfair me assessing a student nurse (radiographer).*

It is interesting to note that out of all the professions in the study, the professions with the longer length of education expressed the least reservations. They were keen to emphasise the benefits of their students being assessed by other professions on these three competencies. The advantages were described in terms of how other professionals might offer a different perspective on how students were performing in practice. It was felt that assessors from other professions might pick up on ‘things’ they would otherwise miss due to working day in and day out in the same profession. This example can be contrasted with clinical physiologists, audiologists and radiographers who were less enthusiastic about other professionals assessing their students and vice versa (1, 7, 16). Whilst audiologist and radiographers have established a professional identity, clinical physiology is in the process of moving towards accreditation of their profession. It might be, therefore, that clinical physiologist’s feel less secure with their professional identity than other professions as they were keen to emphasise the move towards registration.

Whilst it is possible to suggest that how well established a profession is may have some bearing on how willing its members are to engage in interprofessional assessments, it should be noted that doctors already have ‘360 degree’ assessments as part of their training. Thus experience of being assessed by other healthcare professionals, may have a bearing on how comfortable professionals are with interprofessional assessments.

> *Our students get work placed based assessments completed by nursing staff, midwifery, any staff. I get assessed by radiographers and midwives as well. They’re not only structured around many clinical exercise evaluations but there are actually also the 360 degree forms that are completed by multiple professions… (13).*

However, whilst doctors embraced assessments across professions they questioned whether these assessments could encompass all specialities in medicine.

Commonalities

In spite of these reservations participants did agreed that interprofessional assessments could be carried out by specific professions. There appeared to be a relationship between the amount of association an individual professional had with other professions, the knowledge they had about other professions and how comfortable they were with assessments across professions.

> *I think quite a few nurses that I've spoken to don't get on with social worker or midwifery. It would have been the same if you'd have said theatre nurses. There seems to be a them and us….(06)*

Similarly many participants appeared more comfortable with professions they perceived to be like their own, specifically in terms of the tasks they undertook and the decisions they were required to make in practice, when it came to assessing students across professions (see e.g. 16, 13, 04, 19, 16). In this respect several participants appeared to be looking for 'some common ground' between their own profession and that of others when thinking of how assessments across professions could be conducted. Whilst midwives saw themselves as specialists and nurses as 'generalists', they felt they shared features with both nursing and social work. The closer and sometimes lengthy relationship they had with patients or clients (in the case of social work) was identified as a common feature. This view was not always shared by nurses (see above).

> *I think the closest that comes to it would be nurses because I think there's similarities there in that nurses work on wards, we work on wards…..and we do more one to one care where as radiographer and audiologists, clinical physiologist, they don't have continuation of care to the same extent that we have continuation of care and can build up a relationship with somebody (19, Midwife).*

This search for commonality between professions appeared to draw on imagines participants had constructed of other professions and their own profession.

Sometimes these imagines seemed to be influenced by a stereotypical view of other professions, though it was rarely negatively expressed. On occasions it was informed through practical experiences of working with other professions in practice. This could be explained by the participants wanting to maintain a professional image during their interview and not wanting to appear 'put down' colleagues in other professions whom they saw as part of the health and social care system

Medicine was considered to stand out from other professions by the prolonged length of training involved both at an undergraduate and postgraduate level and its diagnostic skills. As a result doctors were seen to have an in depth knowledge, a broader skill base by doctors themselves and other participants such as midwives. Thus finding 'common ground' was seen as difficult. For example, a midwife stated that doctors might be more clinically focused than midwives and nurses who tended to be interested in the whole patient.

> *I think what the doctors are looking for….they not focused on the sort of softer skills…. I saw one of the registrars had a student with him recently and the blood results had come out and he was saying, right what does that mean…so it was very clinically focused. (19)*

Doctors questioned whether other professions would recognise that medical students' assessments 'encompassed quite a few different skills in one task' and wondered if other professionals could realistically assess this. For example they considered midwives to have a limited remit of in terms of what they could and would not do. However, as noted earlier doctors also readily engage in '360' assessments and identified advantages to interprofessional assessment.

Typical view

When participants were asked about whether their opinion about assessing students across professions was typical of their profession, many stated that they were unsure. Responses to this question revealed that this was a subject few participants had thought about previously until asked in the interview.

> *I think it's possibly typical. I think that in ten years time it would be more typical (02).*

As I say, people see things differently, don't they and people have different perspectives (03).

I don't know, you're have to ask the rest of them (08).

A few participants did feel that their view was representative of their profession and others felt it would vary from individual to individual. It was suggested that in medicine a different view might be held by doctors working in academia than those with purely clinical posts.

Other participants flagged up the possibility of different responses between older and younger staff and suggested that older staff might be less open to assessment across professions than younger staff. However, there appeared to no major differences in this study. Although the age of the participants was not recorded during the interviews, length of service and experience were discussed and therefore it is possible to estimate age of the participants. For example, two participants working in the same profession with differing lengths of experience and ages (as observed by the researcher) expressed similar reservations about their students being assessed by other professions. This may suggest that socialisation (culture?) is playing a part in moulding views within some professions rather than age.

CONCLUSION

When describing how and what they looked for in their own students participants reference to professional identity was seldom made in comparison to other professions. Whilst participants frequently point out the requirements of their own profession such as length of training, role expectations and the importance of the procedures they carried out there were few instances of participants attempting to position their own profession above another. However, when participants were asked about their views on assessments across professions, the components advocated in social identity theory such as comparison between in-groups and out-groups and the maintenance of a positive distinctiveness became more apparent in their accounts. Whilst many participants acknowledged interprofessional assessments were possible on the three competencies, communication, team-working and ethical practice, many expressed reservations about the validity of such

assessment and were keen to emphasise the importance of profession specific knowledge and understanding of the role carried out by each profession.

Whilst most qualitative studies have small samples this study should be seen as a pilot study to inform the development of a large study. Indeed, more research needs to be undertaken to explore these findings further in this important, yet under researched area.

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