because the trials were conducted by experienced volunteers, not a wider range of variably skilled and motivated nurses. The division of labour, the rules and funding systems, the perceptions of local professional and lay communities, and the available resources all combine to produce or impede changes in practice,[6] but trials only hint at the contents of these black boxes.

Expansion of primary care nursing

Whatever the implications of these studies for future research approaches, primary care nursing is likely to expand as a discipline, and these papers will be cited widely and correctly as evidence of its importance for modernising the health service. This may be good news for primary care nursing, vindicating the efforts of some nurses to use their skills fully and to extend their clinical roles. It may be good news for general practitioners, who will be able to delegate the demand for immediate care for minor illness to nurses and escape from a sense of being overworked but underemployed. And it may be good news for primary care groups and hospital trusts if unnecessary hospital admissions can be reduced and resources saved by nurse triage. The public may have more mixed feelings, however, and a few may continue to seek medical rather than nursing authority—the affluent with their credit cards and the rest by learning the new system's rules.

The issues for the NHS could be more complex. What roles should primary care nurses occupy? Is demand management in general practice the best use of this skilled professional resource? Perhaps we might learn from north America, where nurse practitioners made up for the physician shortage of 40 years ago and now face managed care and competition. Their future may lie in substituting for doctors in aggressive case management of patients along care pathways and in organising and coordinating team care.[7] Could this be our future too?

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Getting health professionals to work together

There's more to collaboration than simply working side by side

Doctors and nurses work together every day. But is there more to working together than making sure that the work of the one profession dovetails with that of the other? Is there really any content in the "co" words, so popular in government policy documents—coordination, collaboration, and cooperation?

Researchers are beginning to understand what working together can achieve. The settings are different—how work groups in the private sector can perform better,[1] how democracies can involve people more directly,[2–4] how conflict can be resolved[5]—but the message is the same. Working "together" rather than working "alongside" can energise people and result in new ways of tackling old problems. We have had glimpses of this in patient participation in the NHS. We know much more than we did even five years ago about giving lay people the support and information they need to have a meaningful dialogue with managers and clinicians and to make an input into how services are run. We need to encourage real "conversations" at work—ones that start to create a dialogue between people who have not yet understood what they can achieve in common.[6]

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It's the differences that matter

What characterises the new models of collaboration is the recognition that it is not what people have in common but their differences that make collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience. Affirmations, acknowledgment, and recognition are important, but it is the questions and challenges that arise from the differences that are vital. A diverse group can arrive at a place no individual and no like-minded group would have reached. When, for example, a social services department decided to bring people with learning difficulties into the heart of its evaluation of quality, staff realised how inaccessible and unnecessary some of their jargon had become. The direct comments of those in residential care about what would help them in their day to day lives gave a simpler and more motivating starting point for change.[7]

The same kind of thinking is at work when theorists of leadership urge a move from transactional to transformational approaches. A transactional leader has a

strong sense of direction and comes to an agreement with subordinates about what each will do to make a reality of a given vision. A transformational leader is at the centre of a network, allowing a vision to emerge from the dialogue.[8]

What does it take to create the conditions for working together in the new collaborative model?[9 10] Firstly, participants have to welcome challenge. They need to be confident enough to face the unfamiliar, respectful and trusting enough to listen openly to others. Secondly, there must be ground rules. Inequalities of power can make it near impossible for the less powerful members of a group to speak out. Appointing a facilitator and arranging a premeeting to help a minority viewpoint get expressed are ways of organising to redress the balance. Another technique that has been used by teachers when invited speakers with opposing views are addressing a class is to set up a facilitated dialogue. Instead of a traditional debate, where speakers with opposing views defend their own position and attack their opponents', such a dialogue is designed to explore different perspectives, values, and goals and encourages pupils to respect different perspectives on a controversial issue.[11] Collaboration sometimes works spontaneously when established experts are brought together as strangers on a working group or task force. More often, dialogue has to be deliberately encouraged.

There are good reasons why doctors and nurses are not far along this road. Traditionally the profession of medicine created doctors who were self reliant and independent. It emphasised expertise, autonomy, and responsibility more than interdependence, deliberation, and dialogue. The ritual humiliations of medical training that instil individual mastery of knowledge help to maintain this. So too do the expectations of patients and colleagues.

Obstinate traditions

Nursing traditions have been different, emphasising hierarchy and bureaucratic rule following. Even if these have diminished, along with deference to doctors, nurses still work "around" others. Individually, nurses and doctors may strive to overcome the lingering images of their professions, but there is a weight of tradition, including a tradition of gender thinking,[12] to contend with. Nursing is no more conducive to collaborative working than is medicine. Both need to change if a collaborative model is to work.

Support comes from strange quarters. The new National Institute for Clinical Excellence refers to "health professionals" rather than singling out any one group. It acknowledges that no one who works alone can stay at the forefront of knowledge given the speed of organisational and clinical change.[13]

Just how ready are nurses and doctors to work together in a new way? Is it any accident that collaboration between patients and professionals springs more readily to mind than collaboration between the professions? The tales that nurses and doctors each tell about the other when they are outside work and "among friends" suggest that there is still some way to go.

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What's so great about collaboration?

We need more evidence and less rhetoric

A recent white paper on the NHS strongly recommended improved teamwork between professionals.[1] On what basis? How well do nurses and doctors collaborate? Does it matter to anyone? And if it matters, can it be improved? The short answer to all of these questions is: We don't know.

The modern concern with interactions between doctors and nurses began with an opinion piece in a psychiatric journal in 1967. It likened the relationship to a game, a power struggle. The two professions were occupying the same patient care "space," but they communicated indirectly and manipulatively, with little warmth or mutual support—like a bad marriage.[2]

One response has been to reallocate tasks between the professions, and this week's journal reports several studies of such substitution. They contribute to the growing literature on the success of specialisation and delegation as strategies for avoiding the problems of collaboration.

The other response has emphasised joint decision making as the route to better patient care and professional relationships. This idea of nurse-doctor teamwork last received serious attention in the report of the US National Joint Practice Commission, published 20 years ago.[3] Little has been heard of either the report or nurse-doctor collaboration since then. Undoubtedly,

General practice pp 1038, 1043, 1048, 1053

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