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,

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many reasons exist for this, but one is surely the absence of empirical research on the effects of interventions aimed at achieving teamwork.

A Medline search on the MESH term "interprofessional collaboration," including the terms "doctor" and "nurse," produced more than 1000 articles. Almost all were rhetorical or editorial, with some offering explanatory hypotheses or sociological theories. There were few empirical studies of the nature of the interactions, conflicts, and collaborations between nurses and doctors.

Two studies, by the same author, have reported an association between poor collaboration in intensive care units and poor patient outcome.[4] Turning to cause, some studies have reported power differentials and uncoordinated or interrupted communication of patient care information as problems.[5 6] Despite the paucity of evidence, two narrative reviews of the literature have concluded that problems with collaboration are common and widespread.[7 8]

With regard to improvements, two trials and a systematic review have evaluated the impact of joint nurse-doctor ward rounds on patient outcomes.[9–11] Tantalisingly, these two trials hint that working more closely together may be worth while, but we know too little to glibly assert that collaboration has a positive value. To develop and evaluate interventions aimed at improving nurse-doctor collaboration, we will, as ever, need more research.

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Reshaping the NHS workforce

Necessary changes are constrained by professional structures from the past

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The staffing problems of the NHS continue to make headlines.[1] Junior doctors are threatening to strike, consultants are voicing their frustration, and nurses are voting with their feet.[2] Though their concerns are less visible, physiotherapists, radiographers, occupational therapists and other members of the professions allied to medicine are also facing major challenges.[3] The problems have been well rehearsed but solutions seem as far away as ever. If the healthcare needs of this new millennium are to be met, more radical approaches to collaborative working will need to be explored.

By its very nature the healthcare labour force is an interdependent one. The different occupational groups did not develop in isolation from each other but as part of a complex and interdependent system capable of carrying out the many activities that make up a modern health service. Yet despite this obvious reciprocity, the different elements of the NHS labour force are still planned and managed in isolation. This continuing fragmentation has a major impact on the quality of patient care and on the wellbeing of health workers themselves.[4]

Since the 1970s there have been irresistible pressures towards collaborative working across traditional boundaries. More health workers are now organised into multiprofessional teams, and many nurses and those in the professions allied to medicine have taken on innovative roles which sometimes include work previously done by junior doctors.[5 6] These developments have led to some lowering of barriers between different professional groups, but major obstacles still remain.

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Structural problems

Much effort has been put into team building and improving communication skills, but attempts at working together continue to be constrained by differences in styles of learning, in career patterns, in models of working, and in regulatory mechanisms. Moreover, there is still little or no movement of individuals between professions. It is no easier for a highly skilled nurse to become a doctor, for instance, than it was 30 years ago. If the appropriate human resources are to be available to meet the healthcare needs of the coming decades these structural problems need to be addressed.

Current social and demographic trends are likely to continue into the foreseeable future, with the ageing of the population and the rise in chronic diseases leading to greater demand for health care in both hospitals