NURSES LEARNING FAMILY-ORIENTED INTERPROFESSIONAL COLLABORATION

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ABSTRACT

Objectives. A two-year family-oriented interprofessional education programme for professionals working in the field of primary services (e.g. health care, social welfare, school, day care) was started in the Province of Oulu, Finland in 2000. The programme aimed to provide the participants (n=76) with skills to work with families in interprofessional collaboration. The study investigated the views and working methods of all the 14 nurses who participated in the course.

Study design. Qualitative study employing the content analysis method.

Methods. The data were collected by using open-ended questions at the beginning and at the end of the education and analysed with the method of content analysis.

Results. Initially, the nurses were aware of the significance and the premises of family-oriented interprofessional collaboration, but seldom implemented them in practice. At the end of the programme, their working methods had changed from expert- to client- and family-oriented direction. They began to appreciate interprofessional collaboration and found that client- and family-oriented working methods supported families’ own resources.

Conclusions. In order to change the theoretical framework and practical working methods of the professionals a sufficiently long process of education is needed where the interprofessional collaboration is put into practice already during the education. Even though this education programme was developed and implemented for professionals working in the primary social and health care services in the Northern Finland, we believe that it is applicable to the teaching of interprofessional collaboration in different settings in different countries.

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INTRODUCTION

Many authorities have estimated that in the coming 10-15 years, ageing of the population, substance abuse and mental problems as well as obesity with related illnesses (e.g. cardiovascular disorders, diabetes, and musculoskeletal disorders) will constitute the greatest challenge to social and health care services in Finland. Especially in the northern parts of the country, the population tends to be sicker than in the southern parts, and premature deaths and early retirement seem to accumulate there (1,2). Lahelma (3) in his study on the relationship between social class and morbidity among Finns showed that people living in northern or eastern parts of Finland and remote areas were sicker than people in other parts of Finland and, for instance, low social class and poor education were risk factors for health.

In addition to these regional problems in Northern Finland, the society in general is growing more complex, people tend to have more serious problems, and professionals working in the public services are expected not only to have good expertise in their respective fields but also to show competence in interprofessional collaboration. These demands for interprofessional competence are especially pressing in the field of social and health care, which is subjected to notable pressures for change, especially as regards the structure of services and organisations and the staff’s working methods. Clients have begun to demand more humane treatment, more flexible access to services, more professional care and more opportunities to participate in their own care. Various solutions have been suggested, including integration of the social and health care organisations, structural emphasis on community services and better collaboration between public authorities. In small sparsely populated municipalities where a lack of doctors and other health care professionals is always present, collaboration is needed over the community borders. The development of the working methods to a family-oriented direction and collaboration between social and health care professionals have been considered as ways to meet clients’ requirements (4).

The target and action plans of the Ministry of Social Affairs and Health state that in order for these challenges to be met successfully, municipalities must draw up health-promoting well-being plans in which a systemic family and community-medicine approach and the theory of interprofessional work are strongly in evidence. One important objective is to increase the horizontal competence of professionals in family- and network-centred work. This horizontal competence requires interprofessional collaborative skills, which can be significantly promoted by education.

Collaboration competence, consisting of the worker’s skills, abilities and aptitudes, will be one potential domain of competence in the future and it can be significantly promoted by education. Especially interprofessional education has been found to evoke skills that facilitate effective collaboration in practice (5). While examining expertise and its development in primary health care, Launis (6) underlined that, although workers point out the need to develop interprofessional collaboration, they adopt the new way of working slowly and laboriously. Workers may be familiar with the basic principles of interprofessional collaboration and family orientation, but do not work according to them in practice. This was also pointed out by Suosalo (7), who concluded that there were visible signs of interprofessional collaboration,
but no clear-cut or established working methods as yet, and that people were not able to utilise different kinds of expertise. Despite this, the respondents considered their own and their working unit’s operation to be client-centred. Many studies have demonstrated that collaboration in social and health care is problematic, and that there are many obstacles to the fluency of work (6, 8, 9). The major problems hampering daily work include the staff’s tendency to defend their territory and the lack of shared perspectives. Collaboration is also hindered by the lack of time, co-operative planning and resources, different goals and operating cultures as well as ignorance of other people’s work and co-operative practices (10-12). The success of collaboration depends on many factors. In addition to a willingness to co-operate and a supportive environment, the workers need to have personal skills such as education, maturity and positive experiences of collaboration. It is also important for them to be thoroughly familiar with their tasks, confident about their competencies and aware of their limits (13).

The evaluation of, for instance, the family doctor programme indicated that education of a single professional group was not enough to change the working methods (14); this change requires long-lasting collaborative learning of the multiprofessional groups. That is why a two-year family-oriented interprofessional education programme for professionals working in the field of primary services (e.g. health care, social welfare, school, day care) was started in the Province of Oulu, Finland in 2000. The goal of this education was to make the participants capable of interprofessional collaboration and to encourage them to find new ways to help people and to create a new operating culture. This means the prevention, treatment and care of problems and illnesses by taking into account families with their resources and combining the expertise and resources of different professionals in primary health care.

Nursing has traditionally emphasised the significance of family for individual’s health, but it was only in the 1960s that the family was recognised as the client’s background factor and later in the 1970s, when family medicine began to develop, as part of the patient’s holistic care (15). Nowadays, families are considered experts of their respective situations. Family members’ participation in the patient’s care has increased in recent years, but this participation often takes place on the terms and conditions of the health care system. However, as the problems of the clients and their families are increasing in number and complexity, we need comprehensive understanding of collaboration, i.e. doing and managing things together in such a way that theoretical knowledge and its practical application are integrated. The purpose of this study is to analyse the views of nurses concerning interprofessional collaboration and family work at the beginning and at the end of the education programme and to evaluate the changes that took place in their views and working methods during the programme.

MATERIAL AND METHODS

In this education programme, ‘family-oriented interprofessional collaboration’ referred to a way of work where the family was an equal partner in collaboration with different experts. The key issue was to understand the family’s life situation, to recognise the current stage in the family’s life span and to utilise the family’s resources. Family-oriented interprofessional
collaboration requires the workers to have education based on systems theory and the biopsychosocial notion of health (16) as well as the principles of social constructionism (17). In addition, it requires a readiness to serve as both a leader and a member of an interprofessional team. This definition is consistent with the highest level of Doherty’s (18) classification of interprofessional collaboration: ’close collaboration in a fully integrated system’. Workers operating at this level have had education in interprofessional collaboration, they share both power and responsibilities and aim consciously to develop integrated care together with the family. The whole team shares the same vision and work systematically in the same space.

The education consisted of a 20-credit (1 credit = 40 hours/week) programme, and it was carried out as multiple education consisting of contact education (2 days a month, 288 hours) and independent studies (512 hours). During the first year, both days of contact education each month were co-ordinated by the educators, but during the second year, the students themselves organised the first day of contact education in each month, which was called ”self-directed contact education day”. The purpose of these self-organised days was to make the teams assume responsibility for independent work already during the education. The methods included lectures, literature, group assignments, role play, mentoring and students’ study of themselves and their family background (genogramme, family tree) as well as their working communities (network map).

The education was based on a constructivistic view of learning (19), according to which learners actively select, modify and interpret the information they receive and use it as the basis of their new ways of thinking and acting. The cycle of learning proceeds from arousal of awareness through exploration and comparison to application of new knowledge and skills (20). Jarvis (21) defines learning as a contin-

| Thematic area                        | Contents                                                                 |
|--------------------------------------|--------------------------------------------------------------------------|
| Client-oriented work                 | Family- and network-oriented work                                       |
|                                      | Resource utilisation                                                    |
|                                      | Teamwork                                                                |
|                                      | Development of leadership and organisational skills                    |
|                                      | Workers’ ability to cope                                               |
| Changes in life situation and coping | Changes in family and society                                          |
|                                      | Societal family policies                                               |
|                                      | Problem-solving strategies                                             |
| Group assignments                    | Mentoring                                                               |
|                                      | Role play                                                              |
|                                      | Work on oneself and one’s background (genogrammes) and work on the participants’ working communities (network charts) |
| Independent studies                  | Literature                                                             |
| Project work                         | Development of social and health services in one’s own working environment |
uous process of reconstruction of the relationship between the individual and the environment, whereby the learner actively constructs him/herself and his/her reality by choosing and interpreting the information provided by the environment. The key elements of learning are change and individual responsibility. According to this view, the individual must be able to produce and construct a view of the world that enables him/her to experience life as relevant and meaningful.

The theoretical frame of reference of this education programme was based on systems theory and the related biopsychosocial notions of health and illness (4, 16, 22, 23). The key concepts were client and family orientation, interprofessional collaboration, networking and resource orientation. The content of the programme is presented in more detail in Table I.

Material
Seventy-six professionals from primary services, e.g. social workers, doctors, nurses, psychologists, teachers and student counsellors, from the Oulu, Kajaani and Raahen regions participated in the course. The participants were divided into four groups of 18-20 persons in such a way that the people from the same working community or municipality worked together. The education was provided in Oulu, Kajaani and Raahen. There were four educators (n=16) for each group, who worked in pairs during alternate months. All educators were social and health care professionals, and most of them had had advanced specialist level family therapy education.

In this research we analysed the responses of all the 14 nurses, employed in either primary or specialised health care, who participated in the programme. At the beginning of the programme, the informants responded to four open-ended questions: (1) what is interprofessional collaboration, 2) how is interprofessional collaboration accomplished in your working community, 3) what is family-oriented work, and 4) how is family-oriented work accomplished in your working community? The same questions were presented to them at the end of the programme.

Analysis of the data
The data were analysed with the method of inductive, qualitative content analysis, and the main stages of this analysis are presented schematically in Figure 1. The analysis was started by compiling a list of the responses, which were numbered consistently with the questionnaires, to enable the researcher to refer to the original data at the later stages of analysis and to check the reliability of the interpretations (24).

The data were read through several times to obtain an overall view. The unit of analysis was utterance, i.e. a meaningful sequence of linguistic elements (25). The data were reduced by coding the utterances in a more abstract form. This is an example of reduction: 'The family surely know what they are able to do' was reduced to 'confidence in the family’s resources'.

The reduced utterances were classified based on similarity and difference. The classes were mutually exclusive and covered the whole set of research data. The analysis was continued by combining subcategories with similar content and by naming the generic categories thereby created. Category formation was the most critical stage of the analysis: the researchers decided, based on their interpretation, the criteria by which phenomena belonged to a given class or a different class. As the outcome
of analysis, a summarised and generalised description of the phenomenon under study was obtained (26), which is presented schematically in the Results section. In Figure 2, the nurses’ views at the beginning of the education are presented on the left side (2000) and the corresponding views at the end of the education on the right side (2002). In addition to this, the contents of the classes are illustrated by the original expressions. Original expressions are quoted to show the reader the kind of material the categories consist of.

RESULTS

Awareness of family-oriented interprofessional collaboration
Nurses’ views of family-oriented interprofessional collaboration could be divided into four categories: (1) expert-centred way of working, (2) awareness of the client’s needs, (3) awareness of family as a resource and (4) awareness of the prerequisites of family-oriented interprofessional collaboration (Figure 2). The expert-centred way of working was manifested as collaboration between different experts, joint meetings, negotiations or consultations. There was collaboration between the different professional groups within one’s working community, between working communities or between organisations. Expert networks were set up based on the client’s needs or objectives, especially in problematic situations. The goal was to solve the client’s problems. Each expert shared his/her knowledge with the others. The key aspects of collaboration were shared responsibility and shared expertise for the benefit of the client. The client was allowed to participate in his/her care, but the family members were only included “if nothing else helped”. A pair of workers or a network of experts worked to
meet the needs identified by the client, but there was no equal partnership with the client. The following example illustrates the expert-centred way of working:

"People who work in different professions and possibly different formal organisations meet to discuss the client’s problem, trying to figure out a solution for it…”

Family as a resource was mostly described by the nurses with the verbs 'take into account' or 'hear'. Example: "while treating the client and organising his/her matters, his/her family is taken into account" or "the family members are heard about the client’s problems". The goal, however, was to include the family in the client’s care right from the beginning, because the objectives were defined to suit the resources of the whole family. Although the family members were heard and involved at an early stage of the process, they did not participate as responsible members of the team in agreeing on objectives or in finding solutions to problems that would be compatible with the family’s lifestyle. On the contrary, the experts, who were considered important for the process of care by the nurses, participated in decision-making.

The nurses were aware of the benefits of family-oriented interprofessional collaboration, but little, if any, work of that kind was done in practice. The nurses attributed this to the culture of individual work prevalent in public health care. They expected family orientation to increase in the future because there were various development projects under way to promote interprofessional collaboration. Theoretically they were of the opinion that interprofessional collaboration should be based on collaboration between clients and experts. The client relationship should be made up of the client and his or her family, the client’s other interpersonal relations and his/her culture. The family members should be actors, not merely recipients, and they should be present throughout the period of rehabilitation or participate in the planning of treatment or be otherwise available and in contact with the experts.

Collaboration between experts was based on appreciation, understanding and recognition of each other’s work. It was also manifested as utilisation of special expertise, co-operative planning, implementation and evaluation and sharing of human emotions. The following statements illustrate this:

"Appreciating and recognising the contribution of other professional groups and co-ordinating things.”

"We occasionally meet to find out where we are going, what sub-goals we have reached and whether we should modify our methods.”

According to the nurses’ views, family-oriented interprofessional collaboration minimised overlapping tasks, prevented divergent tendencies and enabled integration of different perspectives. Further aims of collaboration were to prevent excessive workloads and to help the staff cope with their tasks. The success of the collaboration depended on the worker’s personality and view of the family. Those with a holistic attitude towards work recognised the significance of the family and took it into account in their work.

**From awareness to practice**

At the end of the education, the nurses’ views of family-oriented interprofessional collaboration included a client-centred way of working and a more profound understanding of family, collaboration and the prerequisites of collaboration (Figure 2). They had internalised the client-centred way of working, which was
Figure 2. Nurses’ notions of the family-oriented interprofessional collaboration at the beginning (2000) and at the end (2002) of the education.
shown by, for example, their reliance on the family’s resources. There were visible signs of the establishment of the operating practice. The nurses reported more and more open discussions between families and experts and they felt that collaboration worked well. People dared to intervene more freely and at an earlier stage than before, and neither clients nor matters were bandied about, but the experts were increasingly well able to assume joint responsibility. The following utterance reflects this:

"We find it natural to contact different experts, as the integration of different views is felt to be fruitful…"

According to the nurses’ views, the participation of the family in interprofessional collaboration was self-evident. Family orientation and networking had increased, and experts trusted in families’ resources. Families had become equal partners in goal attainment.

According to the nurses, the prerequisites of family-oriented interprofessional collaboration were that one had to be familiar with and appreciate other people’s work, which enabled one to hear the views of the client, the family and the other experts. The more familiar one was with the other professional groups’ work, the better one was able to appreciate that work and the more sensitive one was to the views of others. Joint understanding and shared operating models grew out of appreciation of, respect for and familiarity with the others. A positive attitude was also important. Appreciation of others was described as follows:

"Getting to know my partners’ work has opened up new perspectives and enriched my own thinking.”

The nurses understood that better results are obtained when different competencies are combined. Other people’s views widened their own perspectives and contributed to the issue at hand. Their willingness, ability and courage to handle the cases of difficult clients increased. Issues were handled positively and creatively, and progress was made depending on the family’s resources, in small steps if necessary. Here are some examples:

"There is more courage and desire to intervene with the family’s problems at an early stage."

"The education has given me courage to tackle matters, especially matters that I used to find difficult.”

The nurses pointed out that the larger quantity and higher quality of collaboration was a beneficial consequence of the education. Collaboration within one’s own organisation and between organisations had increased. The way of working had made different meetings less monotonous and formal, the informants’ own roles had become more clear-cut, and the new tools and increasing courage had made their work easier. Openness and permissiveness had increased in working communities. This had enhanced the participants’ interest in and desire to develop interprofessional collaboration. These examples illustrate this phenomenon:

"Contacts within our own organisation and within the municipality have increased.”

"Contacts with other partners have become easier and the threshold has become lower.”

"As I have learnt interprofessional ways of working, my desire to develop interprofessional family work has increased.”

The nurses anticipated that it would be easy to continue the interprofessional way of working in their working units after the education. The new working methods and ways of thinking were not specific to a single professional group, but became prevalent in the whole team.
DISCUSSION

Our results indicated that the nurses’ learning process showed signs of constructivistic learning, such as the construction of knowledge through interactive and co-operative processes. Their reflective skills developed in co-operative situations, where a consensus about the family’s complex problem had to be negotiated. The improvement of reflective skills was also manifested in the nurses’ reflection on their own skills and their willingness to share information when making co-operative decisions and agreeing about responsibilities. These features constitute one stage in the process towards new working methods, for a change of working methods can only be attained through understanding and a change of thinking. According to Borgen et al. (27), any change of established working methods takes a long time. They underline that one important prerequisite for being able to get rid of and change learnt habits is that the person is aware of his/her own interpretations and actions. Dialogue is an essential part of this awareness. It opens up new perspectives into the matter and helps one to become aware of the motivation underlying one’s own arguments. The internal model is only changed by experience, but it can also be shaped by education. Education helps the person to reflect on his/her work. This reflective relationship arises from interpersonal dialogue, and it gradually develops into self-reflection. This process consciously aims to enhance self-comprehension, and it may be painful and strenuous.

The nurses’ views of family-oriented interprofessional collaboration were different at the beginning (2000) and at the end (2002) of the education. At the beginning, the nurses were aware of the significance and prerequisites of interprofessional collaboration with families, but did not operate accordingly in their everyday work. Although the nurses recognised the need for family orientation in outlining the family’s overall situation, they mostly used expert-centred ways of working. Launis (6) and Williams (28) also pointed out the tradition of individual expertise and the focus of collaboration mainly on individual clients. Mostly, social and health care workers co-operated and sought for common ground only in an effort to help clients in problematic situations. According to Paukkunen (5), one potential reason for this lack of collaboration could be that the co-operative partners were not sufficiently well aware of the contents of each other’s work. Especially the need to define problems gave rise to contradictory opinions. Nor were the outcomes of collaboration evaluated in sufficient depth, and feedback was rarely given to others. The family as a client was often ignored, and the interaction in interprofessional collaboration was not flexible, which resulted in overlapping work.

At the end of the programme, our findings indicted that the nurses were moving from an expert orientation towards a family orientation, which recognised the client’s and his/her family’s own networks and resources. It appeared that, following the stage of awareness, the significance of collaboration and the family’s resources was acknowledged, and more collaboration was carried out in practice towards the end of the programme. It remained obscure, however, how well this finding reflected a real change in the working methods in different organisations.
It is likely that the findings reflect at least partly the interprofessional group process that took place during the intensive two-year process of education. The evaluation of the whole training group (29) indicated that at the beginning of the programme, the process of change included confusing feelings and anxiety, which decreased as collaboration increased. A similar phenomenon has been reported in other studies on interprofessional groups (30): collaboration is hampered by the differences in perspectives between the professional groups, prejudices and contradictory expectations. As collaboration continues, the parties’ notions of each other as professionals become more favourable.

The change from an expert- to a client-centred operating practice is slow and laborious. The development of new ways of collaboration requires familiarity with the work of the other professional groups and co-operative analysis of the target (6). According to Vogt and Griffith (31), at least three stages can be recognised in change. At the first stage, the workers must abandon their old values and habits. This is followed by a stage where the workers have given up their old way of working, but still find the new operating practice strange and ambiguous. Finally, the workers must become committed to the new operating practice, after which the new practice must become established as part of their daily routines. The present study revealed signs of the first and second stages, which included the decreasing prevalence of expert orientation and the increase of interprofessionalism. No signs of the establishment of the new operating model were seen. However, for a change to be carried out in a working community it is not enough that the workers are working for it, but the administration and the organisational structure must also be flexible enough to permit change. Interprofessional collaboration may be prevented by rigidity or lack of collaboration by the co-workers or the administrative structure. Staff turnover also hinders the establishment of new operating models (14).

During the programme, the nurses’ attitudes became more positive, and the different professional groups began to appreciate each other’s work more. Caldock (19) suggested that interprofessional collaboration, good communication between representatives of different disciplines and awareness of the roles and ways of thinking of other professional groups are factors that promote holistic interprofessional family work. Interprofessional collaboration enables a fluent flow of information, reciprocal exchange of opinions between professional groups, participation in the planning of activities and decision-making and mutual support. Collaboration is promoted by shared responsibility, equality and reciprocity as well as appreciation of the special expertise of each discipline. Interprofessional collaboration improves the quality of work because it allows the client’s problems to be recognised at an early stage.

The credibility of the study
The credibility of the study was evaluated by using the criteria for qualitative research proposed by Burns (32): theoretical connectedness, analytic preciseness, methodological congruence, and descriptive vividness. Each choice by which credibility was evaluated was also a choice concerning research ethics. Theoretical connectedness of the study was enhanced by the fact that the study subjects
described their views freely and in a versatile manner. They had experience of different nursing environments and they were able to evaluate their own work and competence in relation to other workers. Moreover, the researchers jointly analysed the data and discussed the interpretations, referring to the original data when necessary. In cases of discrepancy, consensus concerning the classification was negotiated. Analytic preciseness of the findings, the process of education and the context of the phenomenon under study are described in detail. This allows a reader familiar with his/her own operating environment to evaluate whether the results are applicable to that. Methodological congruence of the results to corresponding situations and working units is enhanced by the fact that the data were collected from nurses working in different environments. The researchers, who themselves participated in the project as educators in the interprofessional family work programme, were deeply committed to each stage of both the educational programme and the research project. When evaluating the permanence of the results, we should evaluate how well the researchers were able to perceive the most essential features of family orientation and to transmit those to the readers. The collection of data in two stages and the close collaboration between the researchers ensured both the credibility of the findings and the validity of the interpretation. Efforts were made to enhance descriptive vividness by describing the different stages of the analysis in as much detail as possible. Comments made by the nurses were quoted in the report to highlight the connection between the results and the empirical data.

**Summary and conclusions**

The most important findings were:

1. Interprofessional education promoted co-operative expertise. Nurses’ ability to share know-how improved during an interprofessional education programme.

2. The education enhanced the nurses’ courage to intervene with families’ problems at an early stage by methods of interprofessional collaboration.

3. Nurses’ views of family-oriented interprofessional collaboration changed during the two-year programme from an expert-centred model towards a family-oriented interprofessional model. The interprofessional operating practice did not yet become established, however.

4. The significance of family-oriented interprofessional collaboration was emphasised during the programme, and the participants began to appreciate collaboration and other professional groups, to hear each other better and to exchange information openly during the education.

We conclude that intensive, process-like education helped to develop interprofessional collaboration. Working methods change slowly, but education provided to several professional groups simultaneously increased the capacity for collaboration especially. Cooperative competence was promoted by the use of reflective and constructivistic methods in education. Even though this education programme was developed and implemented for the professionals working in the primary social and health care services in the Northern Finland, we believe that it is applicable to the teaching of the interprofessional collaboration in different sparsely populated countries.
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