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Crossing Boundaries: developing effective interprofessional relationships between teachers and paediatricians

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ABSTRACT

This presentation is concerned with the professional relationships between teachers and paediatricians in supporting children with special educational needs to reach their full potential. In England, both professions are subject to government legislation and guidance with regard to their own professional practice, including Every Child Matters (DfES 2003) which impacts on both professions. Additionally, the nature of each profession is shaped by their respective professional bodies. While multiple policies have advocated closer collaborative professional relationships, I contend that changes to structures, organisation and processes alone cannot guarantee effective interprofessional working. It is the mutually expressed professional qualities such as respect, advocacy, understanding and empathy that paediatricians and teachers exhibit, leading to improved interprofessional working which are outlined in this study.

Three themes are identified through the literature as having an impact on the teacher/paediatrician relationship; they are policy into practice, professional hierarchy and professional outcomes. In taking a social constructivist approach, the perspectives of teachers and paediatricians are sought with regard to interprofessional working. Phase One of the enquiry comprised of single profession focus groups, where each profession outlined the professional qualities they considered important in bringing about effective collaboration. It is the findings from this Phase that are outlined in this presentation and are presented through the framework of the previously mentioned themes.

Additionally, a conceptual framework is developed whereby paediatricians and teachers can be brought together into a new community of shared practice through the exercising of professional qualities. Such a community recognises complementary competences and owes its cohesiveness to mutual engagement, joint enterprise and a shared repertoire (Wenger 1998). I contend that such communities are characterised by shared goals, shared language and shared identity and are maintained by the recognition of difference, the mutuality of attentiveness and respectful encounters (Veite and Peeler 2007).

Introduction

This body of work stems from my work as a teacher in a mainstream junior school in a city in the north of England. While I was teaching, I was responsible for the special educational provision for over 120 pupils in my school. Many of the needs of these pupils were met through additional support in school, however, for some children their needs required additional support from other professionals, not in education. Many of these other professionals were in the health field, for example physiotherapists, occupational therapists, speech and language therapists and a range of nurses. It was while seeking to gain the advice and support of these other professionals that I became aware of differences in ways of working, different professional cultures and routines, different professional expectations and differences of language and meaning. It was these experiences which became the spur to investigate the nature of interprofessional relationships between paediatricians and teachers and which are outlined in this paper.

The literature points to a range of factors concerned with the way doctors and teachers perceive each other's professionalism and more particularly the outworking of this within their professional practice. These factors have been placed together under three main themes. These are:

- Policy into practice
- Professional hierarchy
- Professional outcomes

Each of these themes is now discussed in more detail and the data from the focus groups is also discussed within this same thematic approach.

Policy into practice

In England, the government Green Paper: *Every Child Matters* (DfES 2003a) requires agencies to work together in order to protect children who are at risk of neglect or harm. Additionally, while the government acknowledges that life chances are unequal, their aim is 'to ensure that every child has the chance to fulfil their potential' (DfES 2003a, p.7). Therefore, *Every Child Matters* (DfES 2003) is concerned with the universal services available to all children, but more specifically with children who are facing 'educational failure' or ill health (p.7). In working more closely together, centring their services around the needs of the child, agencies are expected to demonstrate improved information sharing and assessments leading to earlier intervention (DfES 2003a, p.9).

Following on from *Every Child Matters* (DfES 2003), the Children Act (2004) was published. This required Children's Trusts to be set up by the Local Authority (LA). Within these trusts, workforce reform is a fundamental component. The government has stated its intention to 'value the specific skills that people from different professional backgrounds bring, and to 'break down the professional barriers that inhibit joint working' (DfES 2003a, p.12). With these aims and concerns in mind, the government advocates multi-disciplinary teams, some of which will be co-located around schools in order to promote the development of liaison between professionals and to provide the opportunity for a rapid response (DfES 2003b, p.60-63). This is part of the structural and organisational changes taking place in order to deliver 'world class services' (*Ibid p.91*).

While the structures, organisation and processes required by the implementation of Children's Trusts provide the means for closer interprofessional collaboration, I contend that this alone does not guarantee effective working relationships between professions. This paper therefore examines how a doctor and a teacher might work together in a way which recognises their complementary competences as well as developing a new community of shared practice. Such a community is developed and maintained through the exercising of professional qualities such as compassion, respect, advocacy and empathy.

Professional Hierarchy

Both doctors and teachers are seen as professionals, however, the nature of their professionalism can be perceived differently as shown in Table 1.

This shows that doctors are described as professionals with recognised status, high levels of specialist knowledge and high levels of academic achievement. They are also governed by a powerful professional body which offers a high level of professional authority. Teachers on the other hand are seen as semi-professionals (Johnson 1972, p.30). Jackson (1970) claims that the 'distinct mystique' of a teacher is weak due to mass education, as the tasks that teachers perform are 'within the general competence of those who have been taught themselves' (p.14). Additionally, the professional body which provides governance for teachers is newly formed, has little autonomy and therefore provides little professional authority.

Summary of similarities and differences in professionalism between doctors and teachers

Doctors	Teachers
Professional status recognised	Professional status unsure
Strong sense of autonomy – self regulation	Reduced autonomy - greater government intervention and regulation
Powerful professional body	Newly-formed professional body
High level of specialist knowledge leading to 'distinct mystique'	Some expert knowledge but weak 'distinct mystique' due to mass education
High level of professional status	Some professional status
High level of academic/educational achievement	Some academic/educational achievement Clarify "some" above an below
Long period of professional training	Some professional training required
High level of professional authority	Some professional authority
Some emphasis on partnership with other agencies	Strong emphasis on partnership working with other agencies
Expectation of professional qualities e.g. consideration, respect, as part of professional practice	Expectation of professional qualities e.g. consideration, respect, as part of professional practice

Table 1

All of these factors contribute to the widely held understanding that doctors have greater professional standing than teachers. In working together, this can lead to teachers taking a more subordinate role and leadership being assumed by doctors. This adherence to implicit expressions of professional hierarchy could be seen by the way in which doctors and teachers related to each other and spoke of the other in the focus groups conducted as part of this research. Similarly, the ways in which doctors and teachers perceive children are different as are the expected professional outcomes. White (2002) reognises that while both doctors and teachers seek to optimise a child's function in society, the differences in the way each professional perceives the child leads to differences in their practice, making collaborative practice more problematic.

Professional Outcomes

Roaf (2002) suggests that professionals in the fields of education and health see their care for children from different perspectives and with different outcomes. She comments that whereas health deals with children whose needs are life threatening, education manages children whose needs are related to life chances (p.3). This difference may in part give reason to some of the frustration felt by each of the professionals with regard to the working practices, routines and expectations of the other. Undoubtedly, both doctors and teachers belong to professions where the best interests of children are fundamental to their working ideals and practice, however, each professional is trained to take on the codes, working practices and culture of their own profession. Indeed, adherence to these codes is part of the expression of identity with that professional group. It is through this professional allegiance that the different expressions of each profession are perpetuated.

The Royal College of Paediatrics and Child health (RCPCH) does recognise a change in the way paediatricians view children. It states that paediatricians should be concerned with the 'holistic and life-long health' of children (2002). This acknowledges matters of developmental health and well-being which lends a harmony to the aims and purposes of *Every Child Matters* (2003). In this way, the professional outcomes for paediatricians and teachers are becoming more aligned as there is a professional responsibility for each profession to contribute towards 'helping every child to achieve his or her potential' (DfES 2003a, p.14)

Having identified the three themes that provide the framework for both the literature and the field work, I turn to consider the specific context in which this work took place.

Local Context

This study was carried out in a large junior school in Sheffield, England. The city has 120,000 children and young people, 35,000 of who will need additional support before reaching the age of 19. The city of Sheffield encounters considerable deprivation, but also has areas that are ranked amongst the most advantaged in England (Sheffield Children and Young People's Plan 2006-2009). The Children and Young People's Plan (CYPP) places a strong emphasis on 'integrated services and culture change' (p.5), the creation of new working practices and new relationships for those providing services for children and young people and for 'all services to feel integrated and cohesive at the point of use' (p.8).

In the school where this study was undertaken, the Ofsted report (2005) states that pupil attainment is well above the national average. Seventeen percent of pupils are considered to have special educational needs and two pupils are receiving additional funding by means of a statement. This means that the school have engaged in a rigorous and bureaucratic process, presenting evidence to the Local Authority concerning a child's difficulties. Such evidence, if accepted, provides a 'statement' of educational needs which bring with it individual financial provision for these needs to be met. The educational provision within the school is deemed to be good, including provision for children with SEN.   It is within this environment of high achievement of pupils and clear working practices that the professional relationships between paediatricians and teachers are being investigated.

Methodology

Wellington *et al* (2005) propose that knowledge is 'experiential, subjective, personal and socially constructed' (p.102). Taking this into account, I chose to use methods for gaining knowledge which investigate the experiences of the paediatricians and teachers. This information was gained through qualitative evidence gathered through single profession focus groups. The approach used was deliberately geared towards identifying good working practice in order to avoid exposing any potential points of conflict or tension.

Data collection – focus groups

In this first phase of the data collection process, paediatricians and teachers were questioned in single profession focus groups regarding the skills and qualities they considered necessary in order to practice effectively as professionals and in particular to facilitate effective interprofessional collaboration.

The voice of the teachers

Eight teachers participated in this focus group, identifying professional skills which were aligned to their own competencies and professional expertise. These included such skills as 'thinking on your feet', multi-tasking, time-management, team work, knowing your children and building relationships. They also considered that it was important to be self disciplined, a good listener and to know when to ask for help and how to receive it.

In terms of the skill of communication, teachers included children, mid day supervisors, teaching assistants and colleagues from other professions as being important partners. This is consistent with the requirement from the Training and Development Agency (TDA) which sets the standards for all teachers and award Qualified Teacher Status (QTS). Their Professional Standards for Teachers (2007) state that the word 'colleagues' should be used to include all those with whom a teacher is required to work, thereby widening the scope of professional relationships beyond education alone (p.3).

In considering what professional qualities teachers were required to demonstrate in their professional practice, they volunteered the notion of a professional quality as described by Forsyth (2006, quoted in Goepel 2006, p.14). He defines a quality as being a disposition within the individual; a distinguishing characteristic which when expressed is the essence of professional practice. This is different from subject knowledge or professional expertise. Teachers identified qualities such as honesty, empathy, co-operation, compassion, diplomacy, fairness, integrity and advocacy. They were then asked to consider which skills they thought doctors needed in order to act professionally. Clinical skills such as diagnosing, delegating and 'good bed-side manner' were most readily identified. With regard to the professional qualities doctors were perceived to require, teachers identified some of the same skills as they considered appropriate for themselves. However, they also considered that paediatricians should demonstrate other qualities such as sensitivity, assertiveness, confidence, understanding and being astute; qualities which could be associated with leadership. These provide contrast with the qualities of co-operation, encouragement, being fair and accepting of individuality which they saw as important for their own roles.

Having accessed the voice of the teachers, the same questions were posed to a group of paediatricians as detailed below.

The voice of paediatricians

There were eight paediatricians of varying experience who took part in this focus group. In considering professional skills, medical knowledge was stated to be paramount. Following this, the paediatricians suggested organisation and communication as important. Enthusiasm, flexibility and leadership including motivation were all suggested as necessary skills, along with 'acting in an emergency' 'coolness under pressure', negotiation skills, dealing with adverse outcomes and the stress associated with it. Additionally, paediatricians suggested that 'humility' 'accepting you could be wrong' 'honesty' and 'probity' were all part of the professional skills required of their practice.

Two additional skills were remarked upon by one of the paediatricians. The first of these was the ability to manage unwelcome criticism from both patients and colleagues and the second was the ability to deal with failure. This latter skill was considered to be fundamental and extremely significant. Dealing with the fact that a patient was going to die and the accompanying feeling that 'you can't do anything else' was deemed to be something 'you had to be able to live with'. Alongside this was the need to come to terms with one's own professional limitations.

As for professional qualities, paediatricians defined these as being intrinsic but to be developed and honed. The qualities they identified for themselves were leadership, motivation, thoroughness, persistence, humility, honesty confidence, respect, moderation of views and being human. This latter quality was further defined as being compassionate. Communication was considered by doctors to be an important quality as with teachers; however, this was clearly centred on the patient and their family whereas with teachers, communication involved all those with whom the teacher is required to work. This demonstrates a difference of understanding of what and who is involved in effective communication.

With regard to the specific qualities doctors identified for themselves, they recognised that many of these were relevant and important for many other professionals also. Indeed one of the doctors remarked 'it does make you wonder why you go to medical school'. Doctors considered that 'bravery' was an important quality. The context for this comment was to do with relaying information to patients that would 'lead to some sort of backlash'. Aligned to this bravery was the notion of 'having a strong belief in yourself especially when your judgement is questioned'. Doctors also commented that they felt their training required them to demonstrate a certain self belief as many of the clinical procedures they were required to do required courage. This included the first time they were required to resuscitate a patient, take blood or insert a cannula. While doctors, by their own admission, may have a disposition which enables them to be confident, they also stated that their training develops this quality through the constant requirement to carry out challenging professional procedures carrying high risk consequences.

In considering the professional skills that doctors thought teachers required, there was much overlap between that of the two professions. However, doctors recognise that teachers manage around thirty children at a time and therefore need to show fairness and lack of favouritism between children in a way which was not required of them. Additionally, managing the complexities of a class with diverse needs was considered to be a skill particular to teachers.

Confidentiality was mentioned by the doctors as being of particular concern to teachers. By this they meant that children or parents might impart sensitive information to the teacher, who would need to make a judgement about how to manage that information with other children in the class and with colleagues. They did not raise the issue of confidentiality between doctors and teachers which was seen as a significant barrier to communication by the teachers.

In considering the professional qualities that doctors thought teachers demonstrated it was remarked 'The skills and qualities are the same, it may be applied in a slightly different way and in a different setting'. This was in contrast to the teachers' perspective which did not identify such an overlap between the two professions seeing them as operating with different qualities. However, doctors returned to the discussion of 'failure'. While they acknowledged that the 'failure' of a teacher results in a child not reaching their learning potential, doctors considered that their 'failure' was a different 'order of magnitude'. Furthermore, the doctor's requirement to manage death itself was considered to be more significant and with a heavier emotional burden than managing the consequences of death.

The data gathered from both the teachers and the doctors in their separate focus groups shows how each professional group exercises a range of professional qualities in the execution of their professional practice. This is shown in Figure 1. This figure is a diagrammatic interpretation of the narrative explanations offered and includes the interrelationships of these explanations volunteered and discussed by the focus group participants.

Each profession is subject to varying government policies and operates within the framework provided by their own professional bodies. During training, professionals take on the culture of

their new profession and develop expertise which gives them acceptance. This forms a sense of professional identity which in turn is expressed though unique competences and professional qualities. The professional qualities which are expressed by doctors and teachers shown in Figure 1 are those which were highlighted in the focus groups.

Professional bodies and policies which impact on expressions of professionality: self perceptions of doctors and teachers
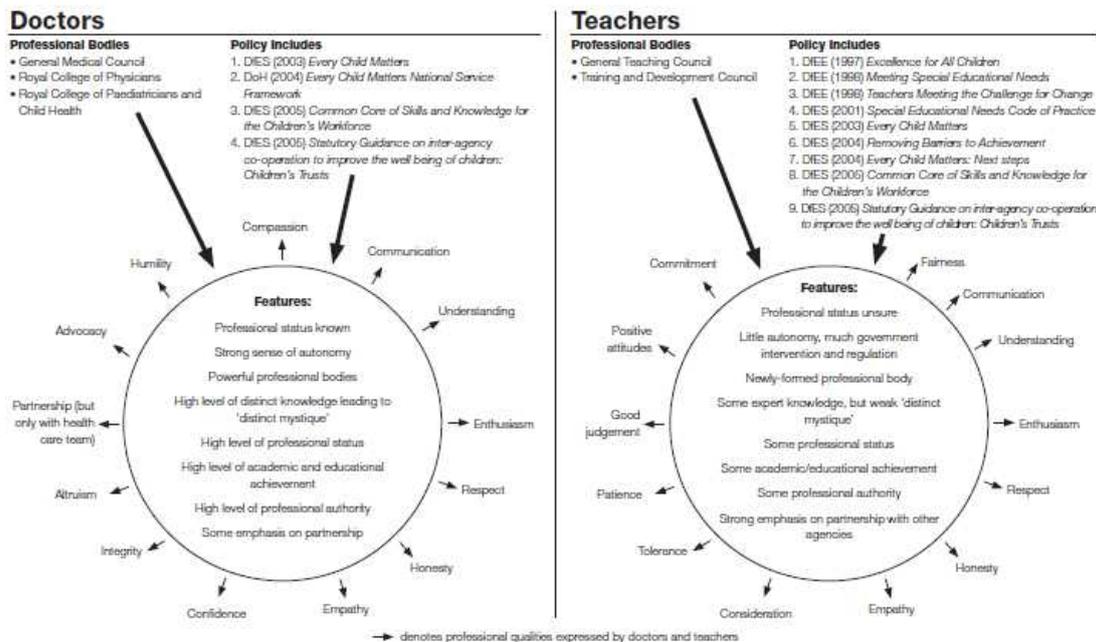

Figure 1

During the second part of the single focus groups, each profession was asked to comment on their view of the nature of effective interprofessional collaboration. The findings from the focus groups are reported below.

Effective interprofessional collaboration

In order to establish the features of effective interprofessional collaboration, teachers and doctors were asked to outline an example where interprofessional collaboration had been successful identifying the professional qualities which were evident. This solution-focused approach was deliberately chosen in order to minimise opportunities for conflict and discord and to promote positive working relationships as befits the nature of this study.

The voice of the teachers

Teachers cited qualities such as respect, having an awareness of each other's profession and roles, trust, confidentiality, realistic expectations, good communication, using readily understood vocabulary and immediate feedback. Teachers wanted to hold shared conversations with paediatricians, to share in the responsibility for children's well-being and to agree on shared goals. They also requested a greater openness between the two professions. Confidentiality was perceived as a 'big barrier' with frustration that parents were often required to act as the conduit for information leading to misunderstanding and sometimes blame.

Teachers were inclined to feel undermined by doctors. One teacher gave an example of having received a letter from a paediatrician asking if she was aware that a particular child had dyslexia as well as being on the autistic spectrum. The teacher felt that her professional expertise was being

questioned. She wanted to be acknowledged for her own professional expertise stating 'I'm a professional too'.   With a greater understanding of each other's roles and responsibilities, along with respect for each other's contribution, these misunderstandings could be minimised.

Similarly, teachers felt strongly that paediatricians did not recognise the difficulties of managing over 30 children at any one time. They considered that doctors advised on strategies and interventions that required one to one attention and were difficult to deliver within a class situation. However, teachers also acknowledged that they had no awareness of the workload of a paediatrician. Yet associated with this was frustration at the length of time taken for a child to be assessed and for a report to be received by the school. During this waiting period, teachers were required to operate beyond their own expertise, with a child who is not progressing, for extended periods of time, on a daily basis. The working practices of paediatricians clearly impact on those of a teacher and therefore having appropriate expectations of each other was cited as key.

The voice of the paediatricians

Doctors also recognised that understanding about the different professional roles and responsibilities of each profession was significant. They suggested that 'listening rather than telling works best' and acknowledged that having experienced successful interprofessional collaboration on one occasion built capacity for trust and positive working relationships in the future. It was suggested that the paediatrician should 'take the teacher's word for it sometimes' even if the parents were suggesting something different. The doctors agreed that effective communication was paramount and that direct dialogue was much better than relying on information relayed by a third party. In relation to communication, 'responsiveness' was also considered to be important. This entailed the prompt acknowledgement of contact by letter or phone call. It signalled that the professional concerned was 'taking it seriously'. Paediatricians also saw the value of 'shared responsibility for the problem' and 'coming up with a plan – a way forward'. This was very much in keeping with what had been expressed by the teachers.

It was clear from each of the focus groups that both doctors and teachers were concerned about gaining an awareness and understanding of each other's professional roles and responsibilities, as well as having realistic expectations of each other. There was a recognition that respect, especially for each other's opinions was important and that good communication was fundamental to effective interprofessional collaboration. These and other mutually expressed qualities form the basis for closer collaboration as seen in Figure 2.

Expressions of professionality showing qualities that are held in common
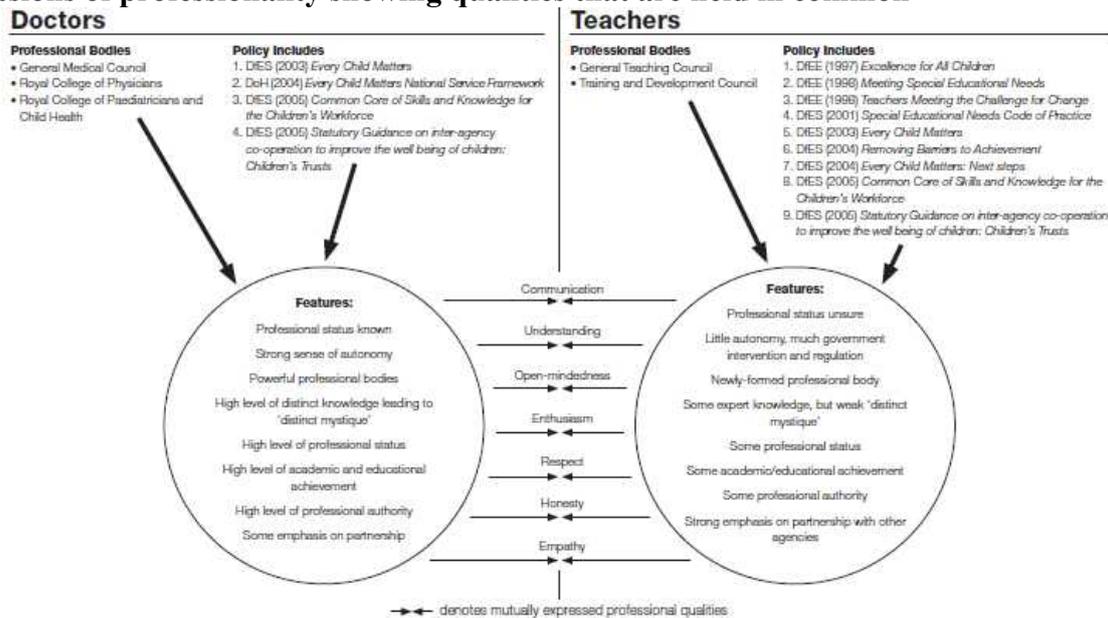

Figure 2

As both doctors and teachers demonstrate these qualities in their professional practice they are drawn together into a new community of shared practice. It is this conceptual framework which is analysed and discussed more fully in the following section.

Developing a new community of shared practice

Every Child Matters (DfES 2003) outlines the need for the reforming of professional cultures and places this responsibility on the Local Authority. In order to bring about such significant culture change, services for children have been restructured and new working protocols introduced. However, the merging of individual professional identities into a new and shared community of practice requires more than just structural change. Wenger (1998, pp.71-72) describes three dimensions of practice as the origins of coherence of a community. These are mutual engagement, joint enterprise and a shared repertoire.

Mutual engagement involves people being engaged in actions whose meanings are negotiated with one another. It is about being able to talk and interact together and being included in the things that matter. Glenny (2005 p.115) calls this interface between professionals 'boundary work'. She considers that a shift in thinking is required for professionals to see this work as 'the core reflective work associated with all professional identification'. This dimension was identified as a desired element by both doctors and teachers in their professional practice and was recognized as under developed in their current way of working. Mutual engagement does not require homogeneity, but recognition of diverse perspectives and skills leading to the expression of complementary competences. Within this community of shared practice each participant is able to develop a unique place and identity, while still retaining the identity which brings allegiance to their own profession.

The second dimension of practice leading to community cohesion is described by Wenger as negotiating a joint enterprise. Such an enterprise depends on a common product rather than belief or agreement. While communities may develop within historical, social, cultural and institutional contexts, Wenger believes that 'it is the community that negotiates its own enterprise' (1998, pp78-80). Through this negotiated enterprise, mutual accountability is developed. In the focus groups,

both doctors and teachers commented on the need for shared responsibility for the child's needs. Teachers requested shared goals and doctors acknowledged that 'responsiveness' was important in working together. Such features can be seen to provide steps towards mutual accountability within the context of the joint enterprise.

The third dimension of practice leading to community cohesion is that of a shared repertoire. This involves stories, routines, gestures, procedures and concepts which have grown up within the community and become part of its practice. It is through these shared histories of engagement that understandings and meanings are negotiated (Wenger 1998, pp82-84). The doctors and teachers in this research had little in terms of a shared repertoire. Some of their previous encounters had provided stories which gave a sense of unease and distrust. While doctors and teachers recognised the professional qualities that could bring about greater collaborative working, they were yet to demonstrate these consistently within their practice. There is a form, a process for shared accountability and articulation and it is the joint working that occurs between teachers and doctors when working with a child in need. The child is seen by the teacher as a student and as the patient by the doctor. There are therefore structures, made even more explicit through the frameworks set out in Every Child Matters (2003), yet cohesive joint working cannot be assumed as seen by the tragic death of baby Peter in the UK in Nov 2008. A step on the journey to improve this joint working, may well be through the mutual recognition and understanding of the shared professional qualities expressed and valued by both professions.

In a community of shared practice, each professional is able to function with competence and for this to be recognised by others. Within such a community a new joint identity is negotiated and formed. While doctors and teachers can remain allegiant to their own professional identity, they also take on the identity of the new community, thereby taking on 'multiple professional identities' (Sachs 2001, p.155) This ability to cross professional boundaries is described by Laidler (1991, quoted in Molyneux 2001, p. 33) as 'professional adulthood'. It does not depend on the systems and organisational structures of joint agency working but rather on mutual engagement through the exercising of professional qualities. Through such mutual engagement, the joint enterprise can be established, bringing benefit to professionals and good outcomes for children.

Having outlined the establishment of the new community of shared practice through the exercising of professional qualities it is important to consider in more detail the nature of this community and what it looks like in practice.

The practice of the shared community

In discussing the features of the new community of practice, I return to the themes outlined earlier in the paper, those of policy into practice, professional hierarchies and professional outcomes. While these could be seen as barriers to interprofessional working, through the exercising of mutually expressed professional qualities, each of these areas can be addressed and new ways of working developed.

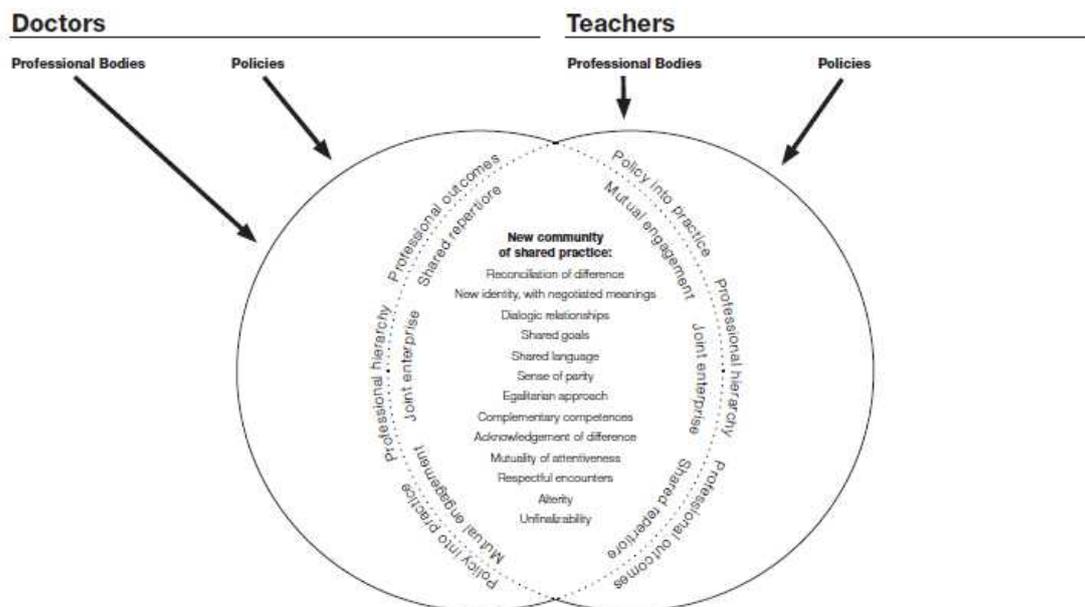**Effective Interprofessional Collaboration through a new community of shared practice**

Figure 3

This figure illustrate diagrammatically the potential for improved joint working, a new community of practice, through the expression of shared professional qualities. It can be seen that there is indeed much overlap, so the potential for improved interprofessional working is tangible, making it real is another matter. However, having a conceptual and theoretical framework for interprofessional working is a helpful step along the journey to improve relationships for the benefit of the child.

Policy into practice

The *Every Child Matters* (2003) agenda requires health and education professionals to work together to adopt holistic working practices and to recognise each other's contribution to this process. Understanding and respecting another's professional roles and responsibilities would provide the means whereby shared goals could be developed through shared conversations and leading to shared responsibility. Developing shared goals provides the means whereby differing professional skills and competencies are valued as each contributes to a common purpose.

In coming together into a new community of shared practice, doctors and teachers enter into unfamiliar territory. There is an uncertainty of engagement, vagueness of enterprise and a lack of shared repertoire. This leads to the need for the negotiation of identity and the development of new meaning through the reconciliation of difference. Difference forms of competence, accountability and of engaging in practice will provide challenge for those who move from one community of practice to another. These need to be reconciled but in the process may give rise to tensions. This is an ongoing and evolving process which reforms identity. It is through the process of reconciliation that a shared repertoire is created and a shared language is developed.

Professional hierarchies

Doctors expressed repeated concerns regarding their responsibility with regard to 'managing death'. They saw this as setting themselves apart from other professions making medicine 'unique or….important'. Teachers on the other hand commented on the frustration of not being able to carry out their own professional practice as fully as they wished due to the need to avail themselves of a professional opinion from a doctor. The doctor's admission that they 'should take the teacher's

word for it sometimes' and that another professional may have 'just as important a view' is the beginning of understanding and respect for one another, as well as one another's opinion. Frank (2004) takes this further by talking of 'making yourself hostage to the need of the other', and recognises that this is counterintuitive (p.53). Furthermore, he advocates that professionals speak *with* each other acknowledging that this requires the determination to disregard any perceived hierarchy or status for the greater outcome of being available to the other.

One of the doctors stated that they felt being human was an important quality. Frank (2004) considers that being human is an unfinished work and that it carries with it the capacity for growth. This growth comes about in part through 'dialogic relationships' with others. It recognises the 'unfinalizability' of another through speaking to them rather than about them (pp.100-101). Through such dialogic relationships doctors and teachers can express mutual respect, understanding and honesty leading to a greater openness, even a willingness to admit to uncertainty. This is described by Veite and Peeler (2007, p.186) as 'mutuality of attentiveness' which in turn leads to parity between the professions. Parity is not about being the same, but about accepting difference and valuing what is offered by the other. In this way, each is being reshaped and through the expression of their humanity a reconstituted professional identity is formed.

Professional outcomes

In the single profession focus groups, the paediatricians were extremely concerned with what they termed 'failure'. For them this meant the death of a patient and was considered to be a greater failure than that of a teacher. However, by redefining failure as 'adverse outcomes', both doctors and teachers can work towards the same outcomes. Children who are not reaching their potential or becoming marginalised from society are in danger or being ignored, isolated and socially excluded. It is vital that paediatricians recognise their professional obligation to ensure optimum development for such children. By engaging in effective inter-professional working, professionality of the highest level is being demonstrated. The common aims of each profession can be seen as the well being of children and in forwarding this purpose each profession can make their own unique contribution and recognise the contribution of the other. Inter-professional dialogue is a vital component of this process.

Frank (2004, p.114) contends that the 'basis of dialogue is a relationship of otherness'. He suggests that otherness implies that people are separated from each other because of their differences but that such separateness can be overcome through dialogue. He refers to the French philosopher Levinas who uses the word alterity to describe an 'intrinsic quality of being human' which when used as a basis for relating and working can transcend differences of working culture, practices and expectations as well as differences of gender, status or hierarchy. Without alterity, interprofessionality will be driven by structures and organisation. While such systems may facilitate interprofessional working, they remain emotionless and detached without due regard to the essence of being human. It is in exercising professional qualities such as respect, understanding and communication that doctors can become fully professional and fully human and as such are more likely to demonstrate their belonging to a new community of shared practice.

Conclusion

This paper has considered the implications of the *Every Child Matters* (DfES 2003) framework which has been implemented in England. This government document addresses the need for agencies to work together effectively in order to ensure that all children are able to reach their potential. While structures, systems and procedures are instigated in order to promote inter-professional collaboration at both national and local level, I propose that this alone does not guarantee effective cross boundary working. In taking a professional qualities approach it is

possible to recognise that many of the qualities are mutually expressed and thereby provide the basis for developing a new community of shared practice. While concerns were expressed regarding implementing policy, professional hierarchies and professional outcomes, such barriers can be overcome through dialogic encounters and the recognition of alterity. In the exercising of professional qualities such as respect, understanding, empathy, honesty and open mindedness, doctors and teachers can acknowledge their complementary competences, developing shared goals and outcomes. By this means, professional boundaries can be softened and a new community of shared practice could be created. Such a shared community of practice, it is tempting to speculate, is highly likely to give rise to a new and corporate professional identity. I contend that it is in each professional expressing their allegiance not only to their own profession but to the new community of shared practice that their professionality is most fully expressed. However, more importantly, it is through such valuable cross boundary working that needs of children can be most effectively met.

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