



The roles of specialisation and evidence-based practice in inter-professional jurisdictions: A qualitative study of stroke services in England, Sweden and Poland



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ABSTRACT

This paper investigates how the concepts of clinical specialisation and evidence influence the jurisdictional power of doctors, nurses and therapists involved in stroke care in Sweden, England and Poland. How stroke care has become a distinct specialism across Europe and the role that evidence has played in this development are critically analysed. Five qualitative case studies were undertaken across the three countries, consisting of 119 semi-structured interviews with a range of healthcare workers. The informants were purposively selected and their perspectives of evidence-based practice (EBP) within stroke care were explored. The data were analysed through thematic content analysis. The two key themes that emerged from the data were the health professionals' degrees of EBP and specialisation. The results illustrate how the two concepts of clinical specialisation and evidence are interrelated and work together to influence the different professions' degree of professional jurisdiction. It is concluded that doctors' professional dominance gives them full jurisdiction in stroke care and that nurses' and therapists' degrees of jurisdiction is dependent on their ability to specialise.

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1. Introduction

There is a paucity of studies of the inter-professional perspectives of evidence-based practice (EBP) (Mykhalovskiy and Weir, 2004), the lived experiences of different clinical professionals working in specific clinical specialities of EBP (Broom et al., 2009) and no comparative European studies that can shed light on the impact of different national health system contexts. This research examined different healthcare professionals' perspectives of EBP and how this influenced their professional jurisdiction. We use Abbott's notion of professional jurisdiction as the theoretical lens to analyse the inter-professional relations in stroke care in England, Sweden, and Poland via five comparative case studies. Stroke care is an ideal condition to investigate these inter-professional

perspectives, as contemporary stroke care is multidisciplinary; care is delivered by a team of doctors, nurses and a range of therapists. We argue that the twin concepts of EBP and specialisation contribute to the degree of jurisdiction that these three different professional groups have in stroke care in England, Sweden and Poland. Before presenting our case study findings we examine the concepts of professionalisation and jurisdiction, evidence in healthcare in general and the development of EBP in particular, followed by a discussion of the development of stroke care as a discrete clinical specialism.

2. Professionalisation and jurisdiction

There is a vast literature on the power of the medical profession (Johnson, 1972; Mechanic, 1991) and its dominance over other healthcare professionals (Freidson, 1970). The intention of this paper is not to present a précis of this important literature, instead we investigate the contemporary inter-professional

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relations in a particular health speciality in different contextual settings. Much of the literature on healthcare professionals' have been uni-professional and ignore the important inter-professional relations. Abbott's (1988) concept of professional jurisdictions is valuable in investigating how and why inter-professional jurisdictional disputes occur within an interrelated system.

We empirically advance Abbott's (1988) argument that "the development of the formal attributes of a profession is bound up with the pursuit of jurisdictions and the besting of rival professions" (p.30). Abbott's concept of jurisdiction is useful to examine inter-professional relations as; "It shows how professions both create their work and are created by it" (p.316). Abbott argues that scholars of the professions had not examined a key aspect of professional life: inter-professional competition (p.2). This competition leads to disputes over jurisdictional boundaries amongst professional groups that determine the history of the professions. According to Abbott the correct unit of analysis is the jurisdiction (p.112), which is defined as a particular area of work that has a distinctive body of knowledge (Timmons and Nairn, 2015: 9). The elaboration of strong evidence has established a distinctive body of knowledge for stroke care that has developed into a professional jurisdiction within which professional groups will vie for control. Before examining the jurisdictional dimensions of stroke care it is important to discuss how stroke care became a distinct professional jurisdiction by considering the key concepts of EBP and specialisation.

3. Evidence-based practice

Evidence-based medicine (EBM) changes medical practice from being primarily grounded on tacit knowledge to one characterised by encoded knowledge (Dopson et al., 2003; Greenhalgh et al., 2008). EBM is not a purely scientific endeavour, what EBM is and how it is defined is contested and hence political (Harrison and McDonald, 2008). Timmermans (2008:167) argues that EBM serves a number of purposes:

EBM offers a dominant and sweeping social mechanism to control unruly individual professionals, regain the public's trust, and shore up the scientific quality of the professional medical project that has spread from physicians to other allied health professions.

This quote suggests that the influence of EBM extends beyond doctors and the term evidence-based practice (EBP) is the inclusive term for the work that all healthcare professionals engage. EBP has become the accepted orthodoxy and is now regarded as normative clinical practice (Lambert, 2006). A key EBP attribute is that not all evidence is considered equivalent, but a hierarchy of evidence which is dependent on the research design and its implied 'validity', which is itself a contested term (Grossman and Mackenzie, 2005). The randomised control trial (RCT) sits at the top of this hierarchy; non-randomised controlled trials, case studies and observational studies occupy lower ranks on the EBP ladder, while qualitative studies are considered comparable to ideas and opinions (Harrison and McDonald, 2008). The EBM pioneers defend this hierarchy by arguing that:

the randomised trial, and especially the systematic review of several randomised trials, is so much more likely to inform us and so much less likely to mislead us, it has become the 'gold standard' for judging whether a treatment does more harm than good. (Sackett et al., 1996: 71)

This dominant view has been criticised by other healthcare professions, such as nursing, which questions its appropriateness to the goals of nursing (Wall, 2008). Critical discussions about how to incorporate qualitative research into systematic reviews and clinical guideline construction to reflect a more comprehensive understanding of the contribution of different types of research to the overall goals of EBP challenges this dominant EBP narrative (Dixon-Woods and Fitzpatrick, 2001; Dixon-Woods et al., 2006). Others have emphasised the importance of distinguishing between effectiveness and efficacy (Gartlehner et al., 2006) in RCTs and the role for patient engagement to improve EBP (Greenhalgh et al., 2014).

Notwithstanding these challenges, for others (Borgerson, 2005), the RCT remains at the pinnacle of the evidence hierarchy, creating a bias to healthcare provision that is amenable to the RCT. This is pertinent for therapists in particular (such as physiotherapists, occupational therapists and speech and language therapists). For example, a study into evidence and the provision of physical therapies for young children with motor disabilities reported that of 444 intervention study papers only 31 met the accepted (RCT type) criteria for evidence (Landsman, 2006). The lack of good quality RCTs for therapists' interventions is often cited in the literature (Landsman, 2006; Leung, 2002). Critics argue that much EBP is inappropriate in therapists' clinical work and that a fundamental clash exists between the medical research and therapy paradigms leading to the "therapies' dilemma" resulting from the medical model of evidence failing to recognise the value of non-RCT research designs (Grimmer et al., 2004). However, clinical practice is not solely governed by evidence, Greenhalgh et al. (2008) argue that it results from the synthesis of professional judgement (tacit knowledge) and formal rule based systems such as EBP (encoded knowledge), concluding that encoded knowledge alone was not sufficient for clinical action.

One might conclude that the development of EBP is an example of what Abbott called an internal source of disturbance, a disruption that occurs from within the professions themselves, that has largely strengthened the medical profession's jurisdictional claims (96–98). However, the impacts of EBP on the medical profession are more complex (Armstrong, 2002). On the one hand the development of EBP challenges the medical profession as it erodes the profession's clinical autonomy by increasing their accountability but on the other, by formulating EBP on a narrow and somewhat bio-medical model of scientific evidence it can perpetuate and preserve the medical profession's dominance among other healthcare professionals (Timmermans, 2005).

In terms of inter-professional jurisdictions EBP can be used by the medical elites to reinforce their power within a medical system, as they are often responsible for constructing evidence based clinical guidelines that dictate the clinical work of nurses, therapists and doctors. These developments create a paradox that diminishes health professionals' clinical autonomy while strengthening their professional autonomy by maintaining control of the construction of clinical guidelines and audit systems (Timmermans and Berg, 2003) and reinforces doctors' professional dominance over other healthcare professionals (Light, 2000). For example, Timmermans and Hyeyoung (2010) argue that the medical profession successfully minimised the challenges to their jurisdiction posed by complementary medical practitioners by incorporating and side-lining their activities, thereby bringing them into their sphere of influence and control. Light (2000) argues that the situation is dynamic; as medical power becomes dominant it is challenged by a range of countervailing powers such as nurses and therapists in the case of stroke who attempt to address the imbalance.

We now turn to how evidence has helped stroke care develop

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