

Interprofessional Education for Collaborative, Patient-Centred Practice

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**“We are in a new place, not on the
edge of an old place.”**

– Sister Elizabeth Davis,
Canadian Health Services Research Foundation,
7th Invitational Workshop, Montreal, 2005

Interprofessional education has been defined as “occasions when two or more professions learn from and about each other to improve collaboration and the quality of care” (CAIPE 1997). Much that has been written about interprofessional education (IPE) and the interprofessional team has concentrated on two or at most three professions, primarily medicine, nursing and pharmacy. Educational programs described in the literature tend to focus on activities involving students, practitioners or both. Very little has been written about

the structural changes that need to be made within universities, colleges and the healthcare industry such that IPE becomes a joint responsibility across a number of jurisdictions that may then effectively influence institutional practice.

These university- and industry-based structural changes are needed because community health and human services correctly view the patient or client as the centre of professional attention. By extension, this view implies interprofessional collaboration in practice, since patient-centred service is clearly beyond the competencies and scope of practice of any one profession, as noted in the report of the Commission on the Future of Healthcare in Canada (CFHC 2002), *Building on Values: The Future of Healthcare in Canada* (otherwise known as the Romanow report).

Interprofessional collaboration is also explored in the report of the National Expert Committee on Interprofessional Education for Collaborative, Patient-Centred Practice (Health Canada et al. 2004) and reinforced in the Health Council of Canada's first report, *Healthcare Renewal in Canada: Accelerating Change* (HCC 2005). As the latter points out, "healthcare delivery models of the future clearly envision teams of healthcare providers working together to meet patient needs" (HCC 2005: 38).

Determining whether skills acquired in IPE are actually translated into practice is a complicated exercise. The exercise requires, for example, that we develop models of clinical reasoning that allow the measurement of change as a function of collaborative (teamwork) experience. Such assessment also illustrates the complexity of issues that are engaged when we discuss health human resource planning. Inherent in the Romanow and Health Council's reports is the notion that the structures that facilitate IPE for collaborative practice will need to be both stable and sustained.

The IPE model requires that collaborations be set up to reflect a holistic process – one that recognizes the many disciplinary and professional interests of the collective. IPE is not about "dumbing down" disciplinary education; neither is it about multiskilling. It is a process that offers continuity and facilitates ongoing trust among professionals.

Challenges: Where Are We Now?

"Health science education needs to be transformed by integrating parts of what are now separate academic pro-

grams and by a focus on team-building" (HCC 2005: 37).

Interprofessional education is not easy to implement for a number of reasons: differences in prerequisites for admission to professional programs; the length of professional education; the extent and nature of the utilization of community and hospital resources for practice (clinical) education; students' freedom, or lack thereof, in the selection of professional courses; time-tabling differences and conflicts across professional programs; faculty teaching loads; research interests of faculty; methods of administration within the various programs; and the powers vested in Deans of Faculties through statutory legislation, for example, through the power to appoint faculty members and to develop curricula (Gilbert 2005).

Providing interprofessional learning experiences that promote and foster teamwork and collaboration is therefore difficult. Finding space in diverse curricula, and times at which students may engage in joint activities, needs creative rethinking of structural obstacles inherent not only in research universities, but also in the college and institute systems where many technical programs are offered.

We need to find not only time and space, but also academically acceptable mechanisms for measuring the effectiveness of IPE activities. Changing existing attitudes (which are frequently influenced by stereotypes) of students, faculty and administration in order to make IPE effective is both a challenge and an opportunity. To promote interprofessional education, and to measure

its effectiveness, we must ensure that students' attitudes towards such work are clearly assessed – on entry to their professional program of study, on completion of their practice education (their clinical/fieldwork experiences), on finishing their professional education and, finally, once they are practising (the last being the most difficult).

Convincing both faculty and students of IPE's value is a major barrier to overcome, making interprofessional teamwork and collaboration seem like idealized goals. IPE in health and human service programs remains at the mercy of fashion and expediency unless a coherent body of knowledge (scholarship) develops on which teaching, learning and practice can be based, assessed and evaluated.

Possible Approaches: Changing Practices

It is proposed that any educational program for collaboration should provide conceptual opportunities to test assumptions that, at the very least, provide data on the relationships among different professional groups as expressed in the values and beliefs held by their practitioners. The data would include, for example, assessment of the knowledge and skills needed to collaborate and work in teams; delineation of the roles and responsibilities of health and human service professionals in a team, that is, what those professionals actually do in their work lives; and evaluation of the benefits of IPE and collaborative care to patients or clients, to the practice of a profession and to an individual's professional growth.

Those working close to IPE have come to realize that opportunities to advance the field exist in a number of different forums, both on university and college campuses and in the community, and that these opportunities need to be described, quantified and incorporated into the general schema for IPE. While it is clear that one size will not fit all occasions and situations, perhaps the greatest opportunities to carry IPE forward exist in the time that students spend in their practice (clinical) education.

At the University of British Columbia we have calculated that approximately 40% of the time of students in health and human service programs is spent away from the main campus, in a wide variety of community settings (where "community" covers the entire range of service provisions). Many large acute care settings can serve as a practice education site for hundreds of students at any time. The opportunities to provide interprofessional learning untrammelled by course scheduling are beginning to be appreciated and maximized.

In British Columbia, the Inter-professional Rural Program, organized through the BC Academic Health Council and funded by the BC Ministry of Health Services, is an outstanding instance of the possibilities for developing IPE in rural communities (BC Academic Health Council 2004). The recent initiative of Health Canada, through the National Expert Committee, calling for proposals to demonstrate IPE partnerships between community and the post-secondary system, is another example of a coherent effort to move the agenda forward (Health Canada 2004).

A multitude of influences have been described that either encourage or discourage IPE. The literature shows that for collaboration to be sustained, the balance of these influences must be such that each collaborating party is able to identify sufficient benefit to itself individually as to outweigh the disadvantages of interprofessional collaboration.

Interprofessional education must confront other particular challenges and needs that seriously impede efforts to sustain it.

Challenges include structural differences between faculty organizations; conflicting university and professional agendas; lack of adequate human resources to implement such programs, both within the university and across the community boundary; complex communication demands, within the university and with its community partners; rotation and replacement of team members; and lack of regular evaluation of interprofessional educational goals and programs.

Particular needs include shared responsibility for management; shared space and equipment for curriculum; innovations in assessment and evaluation tools; and the presence of educators from each profession represented in an interprofessional course, (e.g., HIV/AIDS).

IPE succeeds only when certain conditions are met: when the subject matter requires a team approach; when the effects of IPE can be clearly measured, for example, when critical reasoning skills are enhanced; when claims for resources to support IPE can be justified, that is, support for faculty and students is clearly necessary for

success; when the skills being taught are within the competencies expected of a particular professional team; and when skills and knowledge can be explicitly taught and are clearly transferable, that is, those skills can be moved from one case to another (Parsell and Bligh 1999).

In addition, evaluation metrics have to be developed that will allow the assessment of long-term outcomes – for the client/patient, for the process of interprofessional practice, for individual professionals and for agencies in which collaborations are carried out.

The costs of IPE can be tangible and intangible, the benefits even more so. To apprehend the benefits we need to build a new language and culture of interprofessional education. A clear appreciation of benefits comes through using language particular to collaboration and through the recognition that IPE brings access to a wide range of resources, to new knowledge, to new skills. Most important (and sometimes elusive) are the benefits that accrue through the shared respect, esteem and trust of the interprofessional partners who have been educated together in teams.

The task of educators and practitioners is to turn the concepts of IPE – from either idealized articles of faith or pragmatic responses to gaps in service – into ideas that can be understood intellectually, challenged experimentally and promoted politically. At the same time, IPE must move practitioners beyond the tyranny of autonomous practice; it must be turned into practice that addresses difficulties lying beyond the bounds of uniprofessional activity. If the IPE agenda is to transcend idealistic goals,

we must clarify who gains, who pays, who assesses relevance and who measures outcomes.

In attempting to move this agenda forward, we need to articulate some complex questions: Why do people collaborate in interprofessional teams? What makes such collaboration successful? What makes an effective collaborator in an interprofessional team? What drives the collaborative partnership in interprofessional teams? Some answers to these questions are beginning to emerge, through the work of Borrill et al. (2002) and of the National Expert Committee on Interprofessional Education for Collaborative, Patient-Centred Practice (Health Canada et al. 2004).

As we frame our questions, we need to build models that contextualize the collaborating partners: the care providers, faculty, students and, most importantly, the patients. Much research effort still needs to be devoted to the evaluation of interprofessional teams and interprofessional team approaches.

Despite the best efforts of universities to ensure that their graduates are practice ready, employers' chief complaint is lack of job readiness. Because most health and human service professionals lack effective training in teamwork during their pre-licensure education, they therefore have no explicit training in either leading or being part of collaborative efforts. At this time, although the academic barriers to IPE are clear, workplace barriers to developing fully functioning teams are poorly understood. When training to work collaboratively in teams occurs "on the job," the train-

ing is usually poorly formulated.

We know from the healthcare industry (Kohn et al. 2000), from the Bristol Royal Infirmary Inquiry (2001) and from Canada's National Steering Committee on Patient Safety (2002) that there is a dramatic need for comprehensive interprofessional education of health and human service students. Waiting until students graduate and are on the job is almost too late for true effectiveness of team-based care. At the present time, almost all functioning teams have been built within the health and human service care environment, with varying degrees of success.

IPE should be a coherent and integrated component of pre-licensure education that places the patient in the centre of focus. It should provide opportunities for students from at least three different health and human service educational programs to work collaboratively in teams on matters of mutual clinical concern. It is a program that we have undertaken with considerable energy in the College of Health Disciplines at the University of British Columbia. IPE is largely about curricular change in the widest possible domain and, like all curricular change, is both painful and slow to effect. As we tackle the immensely complex task of entrenching IPE as the norm rather than the exception, it is well to bear in mind words variously ascribed to Calvin Coolidge and Woodrow Wilson: "Changing a college curriculum is like moving a graveyard – you never know how many friends the dead have until you try to move them."



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References

- BC Academic Health Council. 2004 (November 17). Interprofessional Rural Program of BC. Final Report. Victoria: Author. Retrieved April 26, 2005. <<http://www.bcahc.ca/pdf/IRPbc-FinalReport-Nov04.pdf>>.
- Borrill, C., M. West, D. Shapiro and A. Rees. 2002. "Teamworking and Effectiveness in Health Care." *British Journal of Health Care Management* 6(8): 364–71.
- Bristol Royal Infirmary Inquiry. 2001 (July). Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 1984-1995. Final Report. Command Paper 5207. London: Queens Printers. Retrieved April 26, 2004. <http://www.bristol-inquiry.org.uk/final_report/index.htm>.
- Centre for the Advancement of Interprofessional Education (CAIPE). 1997 (Summer). "Interprofessional Education: What, How and When?" *CAIPE Bulletin No. 13*. London, UK: Author.
- Commission on the Future of Healthcare in Canada (CFHC). 2002 (November). *Building on Values: The Future of Healthcare in Canada*. Ottawa: Author.
- Gilbert, J.H.V. 2005 (in press). "Interprofessional Learning and Higher Education Structural Barriers." *Journal of Interprofessional Care*.
- Health Canada. 2004 (September). "Interprofessional Education for Collaborative, Patient-Centred Practice: Call for Proposals." Retrieved April 26, 2005. <http://www.hc-sc.gc.ca/english/hhr/interprofessional/iepcpc_cfp.html>.
- Health Canada, Office of Nursing Policy and National Expert Committee. 2004 (February 17). Interprofessional Education for Collaborative, Patient-Centred Practice. Research Report: Environmental Scan and Systematic Literature Review. Ottawa: Authors.
- Health Council of Canada (HCC). 2005. *Health Care Renewal in Canada: Accelerating Change*. Ottawa: Author.
- Kohn, L.T., J.M. Corrigan and M.S. Donaldson, eds. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press.
- National Steering Committee on Patient Safety. 2002. *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*. Ottawa: Author. Retrieved April 26, 2005. <<http://rcpsc.medical.org/publications/index.php>>.
- Parsell, G. and J. Bligh. 1999. "The Development of a Questionnaire to Assess the Readiness of Healthcare Students for Interprofessional Learning (RIPLS)." *Medical Education* 33: 95–100.

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