

Educating for Quality Healthcare
12-14 November 2000
Brisbane

**Resolving the Barriers to Interprofessional Education
One University's Perspective**

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In a previous paper (Gilbert, et al 2000) we presented an account of an interprofessional module on teamwork, which provided opportunities for students to explore assumption about health and human service related professions and their approaches to patient or client care. It was clear from exercise that quantifying *real* as opposed to perceived values in this form of learning experience is a most difficult exercise. Fundamentally, *interprofessional education* (IPE) should precede *interprofessional collaboration* (IPC) in the workplace (SCOPME, 1997; Zungolo, 1994).

Much that has been written about IPE has focused on two or three professions, for example, medicine, nursing and social work, (Freeth and Nicol, 1998; Pryce and Reeves, 1997; Carpenter, 1995). Those educational programs described in the literature tend to focus on the activities involving student and/or practitioners, rather than on the *structural* changes within universities and colleges that are required to be made in order

that IPE is seen as a joint responsibility across a number of jurisdictions, and impacting a number of institutional practices. It is clear that services which see the patient or client as the centre of concern must, by extension, be interprofessional since this view recognizes that client-centred service is beyond the skill of any ONE profession.

Determining whether skills acquired in IPE are actually translated into practice is a complicated exercise. Understanding etc.

< insert materials from Discussion and Implications in paper >

IPE is not easy to implement due to a number of factors: differences in prerequisites for admission; the length of training; the extent and nature of the utilization of community and hospital resources for education; students' freedom, or lack of, in the selection of courses; time-tabling arrangements; teaching loads; research interests of faculty; methods of administration within the various programs; and the powers vested in the Deans of the host faculties through the University Act.

Thus, providing interprofessional learning experiences through IPC that would help promote teamwork and collaboration is therefore difficult. Finding not only space in diverse curricula, but also times at which students could engage in joint activities, needs major rethinking of structural obstacles in the university.

We need not only to find time and space, but also mechanisms for measuring the **effectiveness** of such activities.

Because changing attitudes in order to make IPE effective is such a difficult process, we need to ensure that we assess student attitudes on entry to their courses; once they have clinical/fieldwork experiences; when they complete their education; and finally, once they are in practice.

The fundamental issue facing IPE hinges on using an appropriate **theory**, which supports **testable hypotheses** about the **collaboration** inherent in IPE and IPC. A suitable theory should recognize and include some fundamental concepts developed by Parsell and Bligh (1999):

- an understanding of the relationship between different professional groups i.e. the values and beliefs that practitioners hold;
- an understanding of the knowledge and skills needed to collaborate and work in teams;
- an understanding of the roles and responsibilities of other health and human service professionals i.e. what those professionals actually do in their work lives;
- an understanding of the benefits of IPE and IPC to patients or clients, the practice of a profession, and to an individual's professional growth.

As Parsell and Bligh have shown, each of these fundamental concepts or themes is open to investigation, that is, they provide testable hypotheses for a theory of collaboration.

IPE is defined as a learning process in which different professionals learn from, and about, each other in order to develop collaborative practice.

In a recent small survey of IPE in Social Work programs in the north of England, Karban and Trotter (2000) found "no real

consensus as to the relevance and appropriateness of interprofessional education and that progress is not only uneven but linked in some very different and potentially conflicting agendas.”

Zwarenstein et al (1999), using the guidelines for systematic review developed by the Cochrane Collaboration, concluded that no rigorous quantitative evidence exists on the effects of interprofessional education. As these authors point out: “The chain connecting IPE, improved educational efficacy, closer teamwork, better care and improved outcomes seems appealingly logical and theoretically coherent, and is often asserted. But there is not widely accepted evidence on which to base the belief that they are linked at all, let alone causally”.

They continue:

“Although IPE is unlikely to cause mortal harm, it may have other negative effects ***and could use up resources that might have been used for proven interventions*** (my italics), and so rigorous evaluation of its effectiveness is advisable before widespread implementation” (pp. 418-419).

It is important to point out that whilst the Zwarenstein study did not find evidence of effectiveness, neither did it find evidence of ineffectiveness. Simply that no such evidence currently exists.

A multitude of factors encourage or discourage IPE. For collaboration to be sustained, the balance of these influences must be such that each collaborating party can identify sufficient benefit to outweigh the disadvantages of interprofessional collaboration. The particular challenges for sustaining include:

1. Structural differences between organizations
2. Conflicting organizational and professional agendas
3. Resource requirements
4. More complex communication demands
5. Replacing former team members
6. Regular evaluation
7. Shared planning of the team's stated goals and programs
(Della's paper *Sustaining Interprofessional Education*)

Needs:

1. Shared responsibility for management

2. Shared space and equipment for curriculum and assessment innovation
3. Regular face-to-face contact between educators

The case for IPE can be made **only** when it is likely to be effective, and when we can measure it. When claims for resources can be justified (how?), when practitioners can be held accountable (measure?), and when skills and knowledge can be explicit, taught and transferable (how?) (Loxley).

Collaboration is understood mostly inductively, that is, through reference to practice. So far, a theory of **collaboration** is very underdeveloped. Without such a theory, practice struggles to make sense of itself and is hampered by the lack of any dialogue with a framework of ideas leading to transferable knowledge and skills.

Collaboration implies an interaction between two parties so we need some general theory relating to interaction, for example: General Systems Theory; Social Exchange Theory; and/or Cooperative Theory.

The collaborative process has key phrases: assessing; building; managing; and evaluating. Reflection of these phases comes through reflection on course planning, experience teaching IPE courses, and literature reviews. The collaborative process does present us with testable hypotheses on various parameters.

Knowledge, skills and attitudes are necessary but not sufficient conditions for collaboration. We need to understand structure, the use and distribution of power, and the purpose and effect of culture. Individual and systemic change are necessary.

Structures need to have open boundaries and means of exchanging resources, information and services; they need to be so organized that they are able to take risks in assessing the balance between costs and benefits; they need to be sustained and stable to ensure "the shadow of the future" (i.e., the expectation that parties will meet again, that is, future and ongoing contact); they need to be set up so that they reflect an holistic process, without discontinuities which prevent it, and enable the buildup of trust. (these comments are from page 80 in the Abuyuan paper)

Evaluation: outcome for client/patient; outcome for collaborative practice; outcome for professionals; outcome for agencies. The costs are the tangible and intangible. The benefits: what are those that build the culture of collaboration? To develop collaboration effectively we need access to a wide range of resources, new knowledge, new skills, respect and esteem of all of the partners, and the development of trust.

< insert figure 5.1 as a blueprint, not a guideline >

We need to turn IPE from either a mystical attitude of faith or article of faith, or a pragmatic response to gaps in service, into an idea which can be understood intellectually, challenged and argued for politically. At the same time, it must be turned into practice which addresses difficulties which lie beyond the bounds of uni-professional activity.

What are the questions then, that we have for interprofessional education?

1. What is the gain of such courses to a professional?
2. Who pays for them? (faculty, central administration, department or other)

3. What is the available time in which to teach them?
4. How relevant are they to needs?
5. What are the outcome competency measures?

Theory is an explanation independent of the phenomenon being studied and is based on principles which are coherent, general and transferable, and of continuing applicability. Without the use of theory, discoveries and understanding remain particular and a body of knowledge does not grow. Unless coherent knowledge grows on which practice and teaching can be based, assessed and evaluated, the enterprise of IPE is at the mercy of fashion and expediency.

How then do we establish **models** for the theory or theories?

Who are our partners in this activity?

- the care providers;
- faculty;
- students;
- and patients in community.

All of these participants form a partnership, that is, a group of two or more parties who interact with and depend on each other,

who collaborate in the activities of their unit and behave in ways that suit mutual expectations (Zander, 1994).

The questions we ask ourselves also include:

- Why do people collaborate?
- What makes collaboration successful?
- What makes effective collaborators?
- What theory drives such questions of partnership?

What we need then, is a theoretical perspective of collaboration that uses the sociology of organizations and extended partnerships. This is a sociology of those participating partners. The sociology of organization features collective action (i.e. participation and collaboration) between and among collaborating individuals or parties; and it describes effective group members or the champions, of which we always need many.

I would now like to turn our attention to some particular aspects of the theory which I think are germane within this context.

First... **functionalism**, which stresses the similarities between biological and sociological structures is viewed as natural

systems, organizations are composed of an interrelated series of processes: it is the interrelationship and the processes rather than one or another separate aspect, which should constitute the object of study when we look at collaboration.

Second... **General Systems Theory** emphasizes the similarity of processes occurring in many different types of relationships. We need, in thinking about systems theory, to use the ideas of:

1. a supply of resources (that is, input);
2. conversion sources (i.e. throughput);
3. and, the production of an object (i.e. output)

Three issues seem to predominate in the work of systems theorists:

1. The nature of the interrelationship of systems
2. The contribution that this network of interrelationships makes to the survival or effectiveness of the whole
3. The nature of systems dynamics (Silverman, 1971)

There are two opposing views of organizations:

1. "Society Makes Man" – the action of the parts is structured by the system's need for stability and goal consensus and emphasizes the processes of integration and adaptation.
2. "Man Makes Society" – organizations are mostly the ever-changing product of the self-interested actions of their members and concentrates on conflict and the role of power (Krupp, 1961).

Within the context that we are talking of, that is, collaborative teams, it is clear that conflicts will arise and there are methods by which to overcome conflicts by changing the organizational structure. So, in thinking about a theory of collaboration and the way in which this might be evidenced in collaborative practice, we might say that the best form of that organization would be:

1. One that attempts to optimize individual and organizational need for satisfaction by encouraging the formation of stable work groups and of worker participation in decision-making.
2. Good communication and expressive supervision.
3. Non-bureaucratic structures which function by the setting of objectives rather than through a hierarchy of authority.

So in thinking about the collaborative College which is being proposed at UBC, we need to consider the necessary conditions for its success and effectiveness and also the qualities that will be necessary to ensure its strength.

Team approaches have been suggested as one of the best possible means for achieving decreased costs to the patient and society at large (Katon, 1995; Mullins, Chaney and Frank, 1996).

Despite the uncritical acceptance of team approaches in rehabilitation, little empirical research exists to support their effectiveness in terms of enhanced functional outcomes (Keith, 1991).

Need driven models to support team approaches to rehabilitation (Mullins et al, 1994).

We also need theoretical frameworks that are explicit and establish structure for creating certain types of team approaches and subsequently, for assessing their value.

What we have to recognize, however, when we discuss the development of collaborative and cooperative teams is that equal role status and equal decision-making power are both unattainable, even in the best of families.

Suggestions for implementing team approaches in primary and tertiary care environments would therefore have to include the following:

1. The proposed models should be explicitly stated in terms of established theoretical frameworks, detailing mechanisms of action and implementation according to such theory.
2. The benefits to staff, patients and families should be explained from a theoretical basis (that is, how does theory predict the ultimate utility of the model?).
3. The "robustness" of the theory should be critically examined in terms of clinical outcomes.

Many treatment personnel lack training in team approaches during their professional education and therefore have no explicit training in either leading, or being part of, collaborative efforts. Much of team training is done "on the job".

There is little empirical data to support the utility of teams in significantly reducing costs and increasing quality of care, or under what team conditions care is optimized. There is little evidence documenting that team approaches in general result in decreased length of stay or higher functional outcomes, and there is little evidence to support the efficacy of one specific type of team model or collaborative effort over another.

There is, therefore, a dramatic need for comprehensive education of health care personnel in team approaches, in their formal academic training rather than "on the job".