

Braithwaite and Associates

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Options for change in health care

The ACT Health inter-
professional learning and
clinical education project:
background discussion paper
#1



The governance and value
of inter-professional
learning and practice

A project for ACT Health conducted by Braithwaite and Associates, an Australian consulting practice providing Options for Change in Health Care.

Inter-professional learning and clinical education: A background discussion paper

Duration of project

August-December 2005

Search period

1892 to 18th August 2005

Key words searched

Words and phrases related to 'inter-professional learning' and 'clinical placement'

Databases searched

- Medline from 1966 to August Week 2 2005
- Embase: Excerpta Medica from 1988 Week 33 2005
- CINAHL from 1982 to August Week 2 2005
- Emerald Fulltext from commencement of the database
- Science Direct from 1967
- PsycINFO from 1892

Criteria applied

We searched for the key terms as listed. Documents were largely limited to English.

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1. Executive summary

In this discussion paper we present the findings of a literature review on the governance and value of inter-professional learning and practice. The information is drawn from an extended review of the literature contained in the companion document *Inter-professional learning and clinical education: an overview of the literature*, and this is the first of four discussion documents. A composite picture of the whole topic of inter-professional learning and clinical placement can be obtained by reading all four documents.

In the literature reviewed, it was found that inter-professional learning and practice:

- Has been actively embraced in health professions since at least the 1950s, and in some cases earlier; it is a maturing field of practice and research;
- Is increasingly seen as a contribution to health reform, in the wake of large national and international patient safety inquiries and health workforce reviews;
- Is seen as actively or potentially contributing to: teamwork, collaborative practice and skills, improved ways of dealing with patient and technological complexity, harnessing the skill mix of the workforce, innovate workplace learning and practice strategies, breaking down of silos between the professions and therefore enhancing professional relations and the understanding of common values;
- Requires the identification of inter-professional competencies, the preparation of effective educators and the development and implementation of curricula at undergraduate, postgraduate and clinical education programs;
- Should be underpinned by further research, particularly in relation to its medium and short term outcomes for patients, professionals and organisations;
- Needs leaders and champions to be implemented effectively in the workplace;
- Is at the core of a patient-centred, partnership approach to service delivery, at individual, team, community and inter-organisational levels.

2. Introduction

This paper is one of a series of four background discussion documents examining inter-professional learning and clinical education on behalf of ACT Health. It is drawn from an extended review of the literature contained in the companion document *Inter-professional learning and clinical education: an overview of the literature*. The four discussion documents are:

1. Background discussion paper #1: the governance and value of inter-professional learning and practice
2. Background discussion paper #2: inter-professional practice
3. Background discussion paper #3: inter-professional relations
4. Background discussion paper #4: clinical education and placements.

Each paper is designed to be read separately, and is written for those with a specific interest in that particular theme. A composite picture of the whole topic of inter-professional learning and clinical placement can be obtained by reading all four documents. Those seeking more information on the project background and methods should contact the consultants.

3. Research methods

The researchers conducted four search strategies to uncover available literature on the topic: an electronic search of six academic databases, hand searching of key journals, an examination of grey literature and websites, and snowballing, i.e., securing important references cited frequently in materials already gathered through the first three search strategies. Once assembled, we categorised the materials thematically and also subjected them to a content analysis technique via Leximancer, a software tool which facilitates the conceptualisation and analysis of large text files. We then subjected our thematic categorisation of the literature to a secondary analysis by the Inter-professional Learning Project Reference Group, a body sponsored by ACT Health with responsibilities for guiding the project, consisting of a wide range of stakeholders from the health and education sectors of the ACT, and across the disciplines of nursing, midwifery, medicine and allied health.

Through this method we found and downloaded 62,436 references and, after subjecting them to several refinement processes, reduced these to 37,812 useful references. These are provided in an additional document: *Inter-professional learning and clinical education 1990-2005: an annotated list of the literature*. Further refinement processes led us to reduce the number of references to the 3,765 key documents used in the project.

4. Discussion: The governance and value of inter-professional learning and practice

4.1 Rationale for inter-professionalism

The concept of inter-professionalism emerged strongly in the United Kingdom and the United States of America in the 1960s¹⁻³ and 1970s⁴⁻¹⁰ although it has been intermittently dealt with in the literature before this.¹¹⁻¹⁴ The demand for inter-professionalism grew out of another rapid period of workforce change, interest in the contributions of social problems to health, and the rise of the quality improvement movement.^{15 16}

In Australia,¹⁷ the United Kingdom,¹⁸ the United States,¹⁹ New Zealand²⁰ and Canada,^{21 22} State and Federal Departments of Health have undertaken reviews each of which recommend inter-professional learning (IPL) and practice. In particular these reports call for: teamwork; new ways of dealing with the increasing complexity of patients and technology; collaboration between professions and between professionals and patients; increases in the skill mix of the workforce; and support for innovative workplace learning strategies.

Inquiries into breakdowns in patient safety have also supported the need for inter-professional education and practice. Calls for improvements in inter-professional collaboration were noted by inquiries as diverse as the Bristol Royal Infirmary Inquiry in the UK (paediatric cardiac surgery),²³ in the Southland District Health Board Inquiry in New Zealand (mental health)²⁴ and King Edward Memorial Hospital (gynaecology and obstetrics)²⁵ in Perth, Western Australia. The most important review of patient safety, the Institute of Medicine's *To Err is Human* (2000), recommends that interdisciplinary team training programs, involving simulation, training designed to improve and maintain skills, as well as improve team member communication, be implemented widely by health care services.^{26: 14}

4.2 Benefits of inter-professionalism

Interprofessional learning has been said to improve communication and trust between different professions²⁷ by improving collaborative skills,^{28 29} thereby reducing the 'silo' effect between professions,^{26 30} enhancing professional relationships^{27 31 32} and facilitating more creative and integrative responses to healthcare.³³ Yet as Burgess and Rafferty^{34: 3} note "... we are only beginning to understand the complexity of this [interprofessional education] as a pedagogic activity, and to develop notions of effective practice."

Inter-professional learning and education deals with the knowledge, skills and attitudes (that is, competency) required for collaborative

practice.³⁵⁻³⁷ It provides students with the knowledge of the contribution of other disciplines, the skills to seek out, communicate with and work with other professionals, and the ability to value such contributions.³⁸⁻⁴⁰ Inter-professional teaching is in itself seen as one way of modelling the interdisciplinary skills required of the next generation of health professionals,^{35 41} although there are some concerns as to the number of academics who are genuinely able to teach in inter-disciplinary modes.⁴² The use of a common curricula across health professions will help in the development of a common worldview including common values, language, and perspectives.^{43 44} As the authors of the Health Canada report on interdisciplinarity argue, *“Changing the way we educate health providers is key to achieving system change and to ensuring that health providers have the necessary knowledge and training to work effectively in interprofessional teams within the evolving health care system.”*⁴⁵

While it can be said that there is general support of inter-professional education, there have been some criticisms. For example, educational institutions have expressed reservations about its implementation. In the UK, the Committee of Vice Chancellors and Principals (now Universities UK) argued that respect for the specialist intellectual and practice base of each profession needed to be maintained.^{46 47} This type of argument is supported by those who feel that multi-professional education is simply an underhand way reducing educational costs and edging towards the idea of a low cost, interchangeable, ‘generic’ health worker.^{48 49}

Other critics argued that the concept of inter-professional education remains unclear, with multiple definitions and multiple objectives.⁵⁰ ⁵¹ Despite these types of criticisms, in recent submissions to the Australian Productivity Commission’s Review of the Health Workforce,⁵² many educational, professional and service organisations argued for the actual or potential importance of inter-professional learning.⁵³ The Committee of the Deans of Medical Schools, for example, stated that: *“In its broadest sense, medical and indeed all of health education is still essentially conducted in silos, although there is now a growing recognition that medical education needs to be contextualised within the needs of the health workplace and coordinated across the education/training/practice continuum. In this regard, the growing provision of health care by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning.”*^{54:6}

The most sustained criticism of inter-professional learning and education is the lack of systematic evidence of its effectiveness.⁵⁵ ^{56 57} The most comprehensive search of the effectiveness of inter-professional education was conducted as a Cochrane Review. It

found there were no studies of inter-professional education which demonstrated that such education had a direct effect on the organisation and care of patients.⁵⁸ In this, and another related report, two of the key Cochrane review authors (Zwarenstein and Reeves) argue that while there was no evidence that inter-professional education worked, neither was there evidence that it did not. Their position is that it is difficult to evaluate the effectiveness of undergraduate (or pre-licensure) inter-professional education because: a) large scale changes (e.g., all of school of health) are necessary to implement this type of educational program; b) these types of changes are often led by 'charismatic' individuals and therefore, are difficult to transfer or replicate and c) in order to assess changes in the attitudes and approaches of students and professionals, 'deeper', longitudinal evaluations are required.⁵⁵

In another study, the reviewers loosened the criteria, but still found a lack of strong evidence. Some evidence, however, was found for the effectiveness of post-graduate (or post-licensure) education. The authors state that even though the interventions they reviewed showed "*more reliable evidence of positive impact on health care processes and outcomes*"^{55:47} several issues remained. The interventions were usually aimed at a local team (i.e. it remains to be seen if the same approach would work on larger, or more dispersed teams), were not theory based (therefore it is more difficult to evaluate the causal relations), were generally responses to problems perceived by those involved (who, therefore, were already committed to their success), were driven and designed by clinicians (again, they often have specific buy-in), and finally, they generally related to the implementation of a structure, guideline or new way of working, rather than the facilitation of collaborative practice per se. Nonetheless, the authors claimed that in 11 of the 14 studies reviewed, five were able to demonstrate statistically significant differences in patient outcomes, including a reduction in mortality rates.

Overall, the literature on the effectiveness or outcomes of inter-professional education appears largely to focus on self-reported ratings of inter-professional programs or courses¹⁷ at an undergraduate level.⁵⁹ Nonetheless, these provide some insight into the effects of such courses. Inter-professional learning based in higher education, for example, had the most positive outcomes in relation to learning experiences, changes in attitudes and skills acquisition, while workplace learning rated positively in relation to changes in the organisation of practice, and effects on patients and clients.⁶⁰ Evidence so far seems to suggest that undergraduate inter-professional learning does seem to have some effect on participants,⁶¹ but there is still no independent systematic evidence as to whether it affects either practice or patients.⁶¹⁻⁶³

While the evidence for the impact of postgraduate inter-professional education is stronger, it is still limited. There remains a need for research into a) the benefits of various models and approaches to inter-professional education at undergraduate, postgraduate and continuing education levels; and b) the impact of these programs in the short, medium and long term on patient care and outcomes in different practice settings. Finally, as D'Eon (2005) points out in a recent article, much of the published literature has essentially been a list of 'good ideas', with few attempts to examine the theoretical underpinnings of an inter-professional approach to either learning or practice.^{16 64} An examination of the theories, both explicit and implicit, which inform inter-professionalism, is essential if the field is to mature.

4.3 Governance and inter-professionalism

Governing inter-professional learning processes and clinical education is challenging. It involves the leadership of fragmented strategies in education and health settings. Inter-professional learning and clinical education are coordinated by various education providers, colleges, professional associations and agencies, government bodies and instrumentalities, and health provider organisations.^{65 66} No one governance model will fit all circumstances and thus any governance response will need to be flexible, and ensure effective co-ordination of efforts across multiple providers, policy domains and funding mechanisms. The keys will be leadership,^{42 67} willingness to negotiate,⁶⁸ and agreement to a common framework for good governance.

Rapid changes in health systems and workforces over the last decade have had a significant impact on the governance of inter-professional and multidisciplinary practice. In the face of seemingly constant organisational restructuring,^{69 70} increased workplace demands and heightened scrutiny as a result of patient safety inquiries,^{71 72} staff turnover has increased and retention rates have decreased. In response to these changes, practitioners, managers and educators have sought to find new ways to improve clinical practice and patient outcomes, while at the same time increasing staff satisfaction.^{28 45}

As new ways of working have emerged,⁷³ along with some modifications to professional boundaries and responsibilities, it has become imperative that professionals address the issues of collaboration and teamwork.⁷⁴ In particular, the rising complexity of medical interventions⁷⁵ as a result in the increase of chronic, complex and multiple morbidities in patients who are living longer, and becoming sicker,^{76 77} all underpin the need for multi-disciplinary interventions.⁷⁸ Success of these interventions rely on inter-professional learning and clinical education. This is seen as a way to facilitate collaboration between and across disciplines,^{79 80} to

improve clinical practice^{81 82} and assist in process of quality improvement in general.^{74 83 84} But as with research on the role of clients in inter-professional learning, the evidence regarding governance is slim.

Health Canada clearly articulated the issues which arise in relation to the implementation and development of an inter-professional approach at a national level. These included time constraints, budget, infrastructure, and institutional climates and cultures. They argue that to foster multidisciplinary approaches, cohesive legislation and policies need to occur at both Federal and State levels.⁴⁵

4.4 The client and inter-professionalism

The impact of inter-professional practice on clients can be seen in two ways. Firstly, the notion of patient (and their carers) as partner is under-pinned by a philosophy of health care service provision which considers genuine collaboration as an important part of an ethical approach to service delivery.⁸⁵⁻⁸⁷ In this sense, working closely with patients reflects a commitment to a more egalitarian, power-sharing and client-centred approach.⁸⁸⁻⁹⁰ In this, it mirrors the philosophical arguments for both inter-professional learning and inter-professional practice.⁹¹ Secondly, partnering with clients in the provision of health care has been shown to result in more effective outcomes, not least of all because the active participation of clients can facilitate more acceptable and appropriate interventions and strategies.^{92 93}

Comparatively little work has been undertaken on the role of the patient as either a participant in, or a beneficiary of, inter-professional learning, although the Institute of Medicine notes that both patients and caregivers are performing tasks once strictly performed by health professionals.⁷⁸ While the exclusion of clients or patients from clinical education, in particular, has been noted⁹⁴ the principle of inter-professional practice is seen as one way of shifting health care to a more client-centred focus. A recent article argues that the definition of 'true interdisciplinary practice' should be "... a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues."⁹⁵ The inclusion of clients as part of health care teams appears to be associated with positive results for both the clients (in terms of better health outcomes)^{96 97} and the professionals (in relation to collaborative practice).⁹⁸

Probably the most advanced example of this approach, at a system wide level, is Health Canada's 'collaborative, patient-centred practice.' This approach is said to involve "... the continuous interaction of two or more professions or disciplines, organized into

common effort, to solve or explore common issues with the best possible participation of the patient.^{99: 28} The report argues that “*By learning how to partner through interprofessional training opportunities, students first begin to be socialized into a collaborative approach to partnering with others. The interpersonal skills that develop through interactions with peers can then be transferred and reinforced in their working relationships with patients and families.*”^{99: 29}

An area which is showing potential is the development of allegiances between health services and community organisations, as representatives of clients. Long used as clinical placement options for practice learning for allied health professionals, the locating of nursing and medical students in community health organisations provides a way of introducing them to community directed health care, clients as partners as well as patients, and other health professionals.^{15 100} One note of caution has been raised in an article which found that some community based models of care have worse outcomes than single discipline models. The authors argue this is because community models force clients into a relationship with ‘invisible’ teams in the institution rather than a personal relationship with the healthcare professional.¹⁰¹

5. Conclusion

We have discussed issues drawn from the literature about the governance and value of inter-professional learning and clinical education. If you have any comments on the issues canvassed in this discussion paper, please do not hesitate to contact us. Alternatively, you may wish to access the other discussion papers or companion documents, available from us or the ACT Health website [<http://www.health.act.gov.au/c/health>].

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