

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
#3



Inter-professional relations

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 inter-professional relations. 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 is the third 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 relations:

- Are based on the principle and practice of collaboration;
- Require the careful handling of professional identities, boundaries and “tribes”;
- Can be considered from the perspective of a variety of organisational models, including analysis of methods of leadership, communication and decision-making;
- At a macro level are shaped by the social, cultural and professional systems within which practitioners operate;
- At a meso level are affected by organisational factors such as levels of support, resourcing and communication processes;
- At a micro level are influenced by professionals’ willingness to collaborate, and to establish trusting and respectful relationships;
- At a team level are said to improve professionals’ ability to deal with complexity, co-ordination, care delivery and creativity;
- Can be effective particularly in critical acute, geriatric, rehabilitative, mental health and palliative care settings.

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: Inter-professional relations

4.1 Professional identity and inter-professional practice

Membership of a professional group is said to form part of person's self concept,¹ which helps explain why perceived threats to that group, or to membership of that group, causes anxiety and even hostility towards others.^{2 3} The creation of professional identity is part of the socialisation process of health professionals, a process which begins with undergraduate education,⁴ but which continues in the workplace. A study of nurses, for example, suggested that their mentors (senior nurses) had more of an impact on their professional identity than their undergraduate training.⁵ Doctors, particularly residents, are also said to model their professional behaviour on their mentors.⁶ As Apker and Eggly (2004) note, "*Research indicates that the occupational identity doctors develop during training has critical implications for their future professional relationships.*"^{7: 414}

This socialisation process quickly develops into professional boundaries and territories.⁸ Inter-professional rivalry, tribalism and stereotyping are known to operate,^{9 10} as is 'turf protection'.¹¹ These have significant influence on the ability of team members to work in a multidisciplinary fashion, as professionals struggle to come to terms with differences in values, language, and worldviews.¹² Add to this the differing accreditation and licensing regulations, payment systems, as well as traditional organisational hierarchies, which act as barriers to cross-disciplinary learning, then what has occurred is the dominance of role over the meeting of patients' needs.¹³ Moreover the stated objectives of multidisciplinary teamwork and inter-professional practice, including the sharing of power as well as expertise, means that this can be perceived as a threat to professional and personal identity,^{14 15} although a number of authors argue that genuine collaborative practice actually leads to the empowerment of all the health professionals involved.^{16 17} Resistance from faculties and educational institutions to implement inter-professional education programs has been attributed to similar fears. The notion that professional identities, power and associated hierarchies might be diluted¹⁸ has been said to cause similar anxieties in some academics and faculties, although a more generous analysis is that the lack of evidence for the effectiveness of inter-professional education may also fuel the reluctance.^{13 19}

4.2 Collaboration

The notion of collaboration is central to both inter-professional learning and practice. Multiple definitions of collaboration occur in the health education and services literature, but most include the concepts of sharing (including in and of decision-making,^{20 21}

interventions,²² information,²³ values^{24 25} and perspectives,²⁶ and responsibilities^{21 24 27}) and partnering (that is a workplace relationship²⁴ based on trust and respect²⁸) for a common goal.^{20 22} Some authors also include the idea of inter-²⁹ or mutual-dependency.³⁰ Most agree that in order for a collaborative approach to be integrated and sustained it needs to be understood and promoted at both organisational and team levels.³¹

Different models of collaboration have been used in both the provision and evaluation of services. Each model provides a slightly different perspective on the elements, factors, processes and outcomes of collaboration. A recent review of collaboration models (D'Amour *et al.* 2004) identified four key types: those based on organisation theory, those based on sociological theories, alliance models, and empirical models.³⁰

Organisation theory models considered contextual issues such as the task at hand, the composition of the team, and the organisational and cultural context, as well as factors such as leadership, communication and decision-making.³² Sociological models consider issues such as the processes of exchange and negotiation, based on trust and differentiation of contributions, which needs to occur in order for collaboration to take place.³³ The alliance model combines social exchange theory with interpersonal factors (such as the assessment of individual and groups needs, the role of 'personal knowing' and social support in the establishment of relationships, and the creation of a 'pact to collaborate').³⁴ The final group, empirical models, is in the first case developed from reviews of literature on collaboration between doctors and nurses, and in the second from interviews between midwives and doctors. The foci of these models are the personal and organisational influences on collaboration, the need for an even distribution of power between these groups and the importance of building a trust-based relationship between professional groups.^{35 36}

There are other ways of analysing models of inter-professional practice. These include: 'loosely coupled' systems theory (said to be flexible enough to understand how groups with oppositional and even conflictual world views can continue to operate, and even flourish together, not despite their loose bonds, but because of them).³⁷ Tuckman's model of the stages of group development (forming, norming, storming, performing, and mourning),^{38 39} and reflective practice models where collaboration is said to be facilitated by health professionals' understandings of their own cultural, value and cognitive maps, as well as those of other professionals.^{25 40 41}

D'Amour *et al's* (2004) work is the most comprehensive analysis of the role of collaboration in inter-professional practice currently

available. The authors reviewed the above models and identified a number of parameters at macro, meso and micro level, which they argue determine the effectiveness of collaboration between professions.³⁰ The following description is drawn from D'Amour *et al.*'s work.^{42 43}

At the macro level collaboration is said to be shaped by the milieu within which professionals operate. The authors consider the impact of different macro systems on professionals' ability to collaborate: the social system (that is, the ability of power relations between groups to either facilitate or block collaboration),^{24 28 44 45} the cultural system (or differences in world views), the professional system (in particular the enculturation into professional values and perspectives versus the valuing of collaboration and difference which, the authors argue, can be brought about through reflective practice)^{24 25 46 47} and the educational system (which, if conducted in a traditional 'silo' model supports a narrow professional view which limits understanding of the contribution of different disciplines).^{23 45}

At a meso level collaboration is facilitated or hindered by factors within specific organisations. These factors are said to include: organisational determinants such as hierarchical organisational structures;^{24 29} organisational philosophy and the way in which it values (or not) collaborative practice;^{24 29} administrative support;⁴⁸ and team resources^{22 47} made available for collaboration (including time and space);⁴⁹ and the creation and support of formal co-ordination and communication mechanisms (such as protocols, standards, and policies for inter-professional practice, as well as formal meetings of all team members).^{49 50}

The micro level, willingness or ability to collaborate is associated with interpersonal relations. In this group the review authors include: individual willingness to collaborate,^{24 51} the creation and maintenance of trust^{24 29 52} and respect^{52 53} between team members, and the ability of teams and individuals to communicate.^{24 47 49 54}

Despite this work it remains unclear which models of collaborative teamwork operate most effectively, or how to facilitate or improve health professionals' willingness to collaborate (or indeed, what to do if they refuse).⁵⁵ Nonetheless, the authors of the Health Canada report have provided a useful model of inter-professional education and practice. Their model links interdisciplinary education to enhance learning outcomes, with collaborative practice to enhance patient care outcomes.

4.3 Inter-professional teams

Many authors extol the benefits of inter-professional teams. Inter-professional teams are said together to address the needs of patients. Inter-professional teams are said to be better able to:

- Deal with complex care needs, and therefore patients with chronic conditions¹³
- Be more effective at coordinating and responding to multiple patient needs⁵⁶
- Deliver care across multiple health care settings, such as community based care and rehabilitation centres⁵⁷⁻⁵⁹
- Reduce the utilization of redundant or duplicate services and provide better quality care^{56 60 61 62}
- Find more creative solutions to difficult problems because of the diversity of their members⁶³
- Work with patients needing critical acute,⁶⁴ geriatric⁶⁵ rehabilitative,⁶⁶ mental health⁶⁷ and/or palliative,⁶⁸ care, and result in improved outcomes⁶⁹ shorter stays for these patients⁷⁰ and fewer medical errors^{71 72}

However, the evidence for these pronouncements is weak. Care must be taken with definitions. An inter-professional team is made up of members from different professions and positions. Individuals bring to the team the specialized knowledge, skills, methods and even attitudes of their disciplines. In an effective team, the members “... *integrate their observations, bodies of expertise, and spheres of decision making to coordinate, collaborate, and communicate with one another in order to optimize care for a patient or group of patients.*”^{13:54}

Three types of inter-professional teams have been identified. Multidisciplinary teams (different professional groups independently or in parallel striving to achieve a common goal),^{53 73 74} interdisciplinary teams (different professional groups actively working together on the same project towards a common goal)^{20 53} and trans-disciplinary teams (individuals transcending professional and discipline groups to achieve a common goal).^{73 75}

Cott^{76: 851} argues that while not explicitly stated, the literature on what is required of an effective health care team applies equally to both single discipline and interdisciplinary teams. In her analysis, research on healthcare teams assumes that: first, team members have a shared understanding of the roles, norms and values of the team; second, the team functions in an egalitarian, cooperative and inter-dependent manner; and third, the combined efforts of shared, cooperative decision making are of greater benefit to the patient than individual decision making. Cott notes, however, that the first two assumptions are not confirmed by research and there is limited

support for the third. In practice, many inter-professionals teams have in the past frequently worked in parallel, rather than as an integrated group.⁵³ As Lowry *et al.* comment “*There were no common goals, but each group’s goals stemmed from its professional education.*”^{77: 76} Moreover, some teams have been described as being fraught with conflict and dissonance.^{78 79}

Øvretveit’s work provides further insight into the functioning of multidisciplinary teams. His five point schema exposes the more specific characteristics of such teams, that is: their degree of integration, the degree to which they hold to collective responsibility, the membership of the group, the client pathway and decision-making processes and the management structures.⁸⁰ The question remains, however, how best to facilitate these processes within a service environment. There are arguments, for example, that inter-professional collaboration is also affected, negatively, by changes to the organisation of care. A move toward market driven service delivery, along with rationing and restructuring is said to cause tensions between managers, professionals and patients, and therefore affect their ability to collaborate.⁸¹ An alternative view is supported by Jones *et al* who claim that health service restructuring, and in particular changes to the hierarchical nature of health service teams, has supported more collaborative approaches.⁸²

Poor levels of success in forming multidisciplinary teams provide a strong argument for active and early inter-professional training. As Clark⁸³ and Lynch argue,⁸⁴ simply putting people from different professional backgrounds together in a team guarantees neither co-operation nor collaboration. Morrow *et al.* (2005) point out that active interaction on an ongoing basis is required for effective inter-professional teams, including inter-professional team meetings. They conclude that ongoing training and professional development play a significant part in improving interactions and reducing ‘professional anxiety’.⁸⁵ Curran *et al’s* (2005) evaluation study (using self-reported pre- and post- test time series study) of an undergraduate inter-professional HIV/AIDS program showed that students involved felt that their increased awareness of their and others’ roles and their exposure to inter-professional learning had led to improved attitudes towards teamwork.⁸⁶

5. Conclusion

We have discussed issues drawn from the literature about inter-professional relations. 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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