

Interprofessional learning—what is it and why is it important in a health reform environment?

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I would like to initially acknowledge the traditional owners of the land we stand on here today and thank them for their enduring patience as we work through these issues.

As I am the first cab off the rank here this morning, and there are others talking about this important topic, I thought I would position my presentation as a starting block and use some of my own experiences as a health educationalist to kick it off.

I am going to talk about interprofessional learning or education and why it is important, using the UK examples applying them to the Australian experience; as well as the outcomes we can expect if we do so.

About my background

I will tell you a little about my background so that I can position this paper based on my view as a health educationalist. The very first accredited curriculum I ever wrote was in 1991 for Queensland ATSI HW. Over the next 20 years I wrote other curriculum in general practice—RACGP, rural and remote medicine—ACRRM and Flinders University, nursing—Uni SA, pharmacy—JCU and CDU, and allied health—SARRAH. In all, I have probably written over 40 curricula, plus many educational resources to support them over the years. I have also worked with and for many universities in Australia. This is probably why I have grey hair even though I am only 32!

The thing that struck me however, as I developed these curricula, was that when I looked at the roles of health professionals—doctors, nurses, pharmacists etc—I realised that there were more similarities than there were differences. In fact I can even admit to be cutting and pasting objectives from one curriculum to the other because the issues, especially in a rural and remote context were exactly the same.

So what was the same?

The things that were similar or the same were those things we all have to do as health professionals—how to communicate effectively with people (one of the hardest things students have trouble with in the workplace initially), how to organise and manage ourselves as health professionals (one of the reasons new graduates are seen as not 'work ready', and why I believe all health professionals need compulsory intern years), how care is organised and managed, and to know about the legal and ethical issues associated with the care we provide. The only things that are different are the clinical roles we perform.

Yet when I was at a workshop on interprofessional learning a few years back, I was talking to the dean of a university whom I won't name, and he told me that he thought we were doing IPL really well in Australia. I was fascinated and asked him what they were doing at his university. He told me they were very successful as they now had surgeons and anaesthetists talking to each other. Once I collected my jaw off the floor, I sat back and reflected about this discussion. Is this what people leading university directions in preparing the future health workforce think IPL is?

Since that time I have talked to many other deans, professors and leaders of professional groups and realise that many do not understand what interprofessional learning is, what its purpose is, the outcomes they can expect, nor how to implement it. Many appear to think that it means sitting two groups together in lectures on something like rural health, hoping they learn from each other by osmosis, or putting health students together to learn anatomy and physiology. Of course that will never work, because what each profession needs in this regard is different. For example: What a speech pathologist needs to know about the muscles of the tongue, compared with a nurse or physiotherapist, is totally different. So it's not about anatomy and physiology.

What is IPL?

So what is IPL? It really is very simple. To use the UK definition it 'when two or more professions learn with, from and about each other to improve collaboration and the quality of care' (Interprofessional Education: A Definition, CAIPE, 1997). So essentially it includes three facets—*"Learning from, with and about"*. So the purpose is not just ticking the 'we have IPL box' in the university program, it is about creating safe collegial environments where students can learn from and about each other and the practice of being a health profession with each other. For this to occur it must happen in small groups not lecture theatres. And the focus must be on the patient as the centre of the activity, not the health professional.

I emphasise here, from the very beginning, that this is about modernising and preparing the Australian health workforce for the challenges we will face in this 21 century—chronic disease, an ageing population and an existing workforce trained in the acute care model. This includes how we keep workforce up to date with the significant technological changes that we are currently experiencing; its also about organisational change of our whole systems; as well as change in the way we think, see, manage and do.

So why is IPL important?

We know that the major stuff-ups we make in the health often relate to poor communication between the various disciplines, that there are power struggles about who is in charge, yet we continue to work and learn in disciplinary silos. Nowhere are these powerful class structures more so, than in the UK; nor hierarchies more reinforced than in the medical profession as well as the nursing profession with its military foundations. And of course they are great sparing partners.

So let me just give you an overview of the UK example first, as they along with Canada are world leaders in interprofessional learning and collaborative practice and there are many things we can learn from them in our current health reform environment. What I am about to tell you is the story that was the impetus to national policy being developed in IPL in the UK; something we still don't have in Australia. I had the pleasure of travelling to the UK 4 years ago and working for a week or so with Prof Debra Humphris, the Centre for Excellence in Interprofessional Learning at the University of Southampton. And it allowed me to see some of the great and interesting work they are doing and the resulting outcomes.

Historical overview

There had previously been a few different tries to get health professionals in UK to learn together from as early as the 1960s. But the main impetus came from what is known as the Bristol Report published in 2001, which led the reform agenda for the National Health Service (NHS) and the way in which they educated their future workforce.

I'm not sure how many of you know about this horrendous report regarding the deaths of up to 100 children and toddlers who had cardiac surgery at the Royal Bristol Infirmary, of which 29 were investigated in the inquiry between 1984 and 1995. How it came about was an Anesthetist Consultant, Dr Stephen Bolsin, noticed that paediatric cardiac surgery took three times longer at the Bristol Infirmary than other hospitals, and many routine surgeries were resulting in death. He discussed it with his colleagues and started keeping stats on what was happening. He reported it to management. His response from management—'just keep the train moving, and don't pull the communication cord'. The surgeon he reports is then promoted to director of the hospital. Dr Bolsin, the whistleblower, is then painted as a fairly inexperienced doctor by other consultants in his profession—so the power and class struggle begins.

Later the Bristol report describes the hierarchies and professions in the NHS as tribal. They said "... in the NHS, there were cultures in nursing, medicine and management that were so distinct and internally close knit that

they were tribal” ... that there was competition between the tribes and the danger of this in an organisation where there are numerous tribes is, that they threaten to undermine the capacity of a large organisation to adhere to a set of agreed core values ... and when the tribal groups fall out or disagree over territory, in an organisation like the NHS, then the safety and quality of the care given to the patient is put at risk”. Safety and quality.

Does any of this sound familiar to you? Maybe just the word Bundaberg is enough to prod your memories. The story about a surgeon, an administrator who wouldn't listen to a whistleblower nurse, who was not considered high enough up the pecking order to be respected for the information she provided ... and of course many people died unnecessarily. So you can see why this is important, it is about providing collaborative, safe, quality care and respecting each other in the very privileged roles we perform as health professionals.

The Bristol reports recommended significant change, which included Broadening the notion of professional competence, it said:

1. Greater priority be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals:
 - a) skills in communicating with patients and with colleagues;
 - b) education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management;
 - c) the development of teamwork;
 - d) shared learning across professional boundaries;
 - e) clinical audit and reflective practice; and
 - f) leadership.
- for multi-professional teams to learn, train and develop together.
- All those preparing for a career in clinical care should receive some education in the management of healthcare, the health service and the skills required for management.
- Greater opportunities should be created for managers and clinicians to 'shadow' one another for short periods to learn about their respective roles and work pressures.

And many other recommendations. It was from this that the government focused their reforms and developed national policy and pilot sites to implement IPL across the UK.

The *New Generation Project* resulted, and included the restructuring of the scope of practice of health professionals using horizontal, rather than vertical or siloed approaches to education. Interprofessional learning that occurs from the first undergraduate year across the health professionals.

The example I saw when I was in the UK was at the University of Southampton, where they put 11 professions from two universities together in their first year groups. There were 1500 health students all in the town hall ... as that was the only venue where they would all fit. They put up pictures of real health professionals up and got the students to guess what profession they were from, as a desensitising exercise. They then broke the students into mixed groups of 10 and gave the joint activities to work on. They were placed in a situation where they had to learn from, with and about each other. These were units that ran across three years of their education and were assessed and compulsory parts of each curriculum.

Over the three years students learnt

- Initially about interprofessional practice through observation and interaction with real team—A&E, community mental health, drug and substance misuse teams.

- The following year they learnt about an aspect of practice through completion of the group tasks eg projects etc
- In their final year they experienced and learnt about team work by working together to achieve the group task. Such as clinical audit and review.

Where those students who were in 4 and five year programs the IPL units spanned across their years. So for example, medical students undertook the program in their first third and fifth year.

This, of course, was not just about student learning. It was also about the teachers. It also included a total change in the way in which the teachers across these disciplines thought about what they did, as well as staff orientation, learning how to do it and gaining their commitment to make it happen ... a change process in the way in which everything is organised and viewed. Not an easy thing to do in a university, especially where many programs had run for years and where there would have been the issues such as crowded curricula, no spare time, no physical space, and the joint university nightmares of timetabling and placements etc etc. I have often said changing a curriculum is like moving a graveyard ... you know you never knew how many relatives someone has until you try to move great aunt Molly to the top of the hill when we all know she liked it by the river.

So what have been the outcomes of this extensive process?

What is the evidence?

There is also now emerging evidence that interprofessional collaboration is resulting in:

- lowering patient mortality—saves lives
- improving patient safety
- improves the quality of care
- improving health services
- focuses on the needs of service users and carers
- reduces hospitalisation and associated costs
- enhances patient satisfaction
- improves levels of innovation in patient care and
- promotes interprofessional collaboration
- increases staff motivation, wellbeing and retention
- encourages professions to learn with, from and about one another
- respects the integrity and contribution of others
- increases professional satisfaction

so it is really important stuff when you want to reform a health system for the challenges of the future.

However it is not just the UK and Canada that are having success and positive results, the WHO report that Interprofessional education and collaborative practice for improved health outcomes. They report that there is now sufficient evidence to indicate that interprofessional education enables effective collaborative practice which in turn optimises health-services, strengthens health systems and improves health outcomes. In both acute and primary care settings, patients report higher levels of satisfaction, better acceptance of care and improved health outcomes following treatment by a collaborative team.

Scope of practice

The other really interesting thing they did that I want to talk briefly about, was that they looked at the roles of health professionals and their scope of practice to see what each role entailed and if the scope of practice was going to meet the health care needs of their population in 20 years time—who like our population are ageing, have increased incidence of chronic disease.

As a result of this process of looking across the disciplines and their scope of practice they introduced generic health worker training where students enrolled in a generic health professional course and then chose which discipline they wanted to go into in their second or third year. The impetus from this came from another review they did where they identified patients in the community who were receiving up to 20 health care visitors a week, to do their various bits.

I will give you one example regarding a diabetic man who had a hip replacement and lived 20 miles from the health care team. The OT would drive out to make sure he was positioning his leg properly and had the right facilities in his house, the community nurse came to check on his BP, the dietician reviewed his diet, carer came to bathe him etc etc. Each one travelled in a health car 20 miles each way to do so. Why couldn't one generic health worker review all of these things and seek advice when they needed to. As I'm sure you can appreciate the cost and lack of efficiency in doing this for an ageing population of 60 Million, who are also experiencing a rapid increase in chronic disease.

The Australian experience

So interprofessional learning are words we now often hear frequently in the health workforce and policy reform areas in Australia. Yet the term I believe remains poorly understood and I have found that it receives a lukewarm response in many universities responsible for implementing it, due to the similar problems of power, lack of understanding of other professions roles and a lack of goodwill to bring about change, hence confusion exists. In Australia we had the 2005 Productivity Commission report on *Australia's Health Workforce*, which I quietly fell in love with I would have to say. They recommended radical change, some of which we are seeing come forth such as national registration and accreditation, workforce innovation, interprofessional approaches to learning. But I would have to say this has been painfully slow despite the advent of Health Workforce Australia in setting up systems to make it happen.

Additionally, as someone who is very much a bottom up person, I am disappointed to admit that this has to be a top down process or it won't work. There must be strong national policy, committed leadership and a reorganisation of systems and incentives pushing it hard to make it happen. It is all well and good to say we need IPL and we will use interprofessional approaches in our learning for collaborative practice. I have worked with unis doing this and really, if I am to be honest, it really is very disappointing the lack of leadership and emphasis being placed on this really important issue. I have seen that unis are employing people at lecturer level to implement these approaches, so hence they have little or no power to bring about change required. We still have deans of vertical disciplines such as nursing, medicine, physio etc but we don't have a dean of important horizontal initiatives such as Interprofessional Education that I am aware of. I can only name one university that has just appointed a Prof of IPE, and that is here in WA, but they wanted someone who was a registered clinician, which I don't entirely understand!

A way forward

Unlike other countries Australia has no national IPL policy or guidelines regarding what it is and how it could be implemented, despite billions being spent on health workforce reform. We need national policy to make this happen. We need people to think outside the square and see its potential. We need to place the patient at the centre of the learning, not the health professional. Patients really don't give a shit who does what, they just want to easily find their way around the system as economically and efficiently as possible, and get well.

As an educationalist I really don't want to hear any more about the barriers, oh it won't fit into the timetable, our room isn't big enough, or we have always done it like this. It should not be optional, it is about improving the quality of health care, patient outcomes, could anything be more important? We know as health professionals that the impact we have upon a persons health is about 10% on a good day. The other 90% is affected by the social determinants of health—their housing, their diet, their income, social support etc. So we need to make sure our 10% has the desired impact.

Rural approaches

I believe that we who live and work in rural and remote Australia are extremely well placed to lead the way in this important area, not because we necessarily want to, but because we already do this stuff due to the scope of our practice. We have to work as part of a multidisciplinary team especially in remote Australia. We have to acknowledge, understand and respect each other's roles, and we need national policy based on best evidence to ensure a sustainable health workforce and the goodwill to do so.

Recommendation

I would like to make the following recommendation:

Health Workforce Australia, in consultation with the professions, universities and the Dept Health and Ageing develop national policy and guidelines to implement compulsory interprofessional learning and educational approaches across all medical and health professions.

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