Interprofessional learning:

The solution to collaborative practice in primary care

Sue Pullon and Eileen McKinlay

Correspondence to: sue.pullon@otago.ac.nz, eileen.mckinlay@otago.ac.nz

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'The combined skills of a nurse and a doctor together create a team much more than the sum of its parts'[1]

Key words

Interprofessional education, primary health care, teamwork

Introduction

Worldwide, there are increasing options available at postgraduate level for health professionals to undertake interprofessional education. Interprofessional education provides a route to improved interdisciplinary health professional teamwork;[2] an imperative of all health and social services.[3] New Zealand authorities such as the Ministry of Health (MoH)[4] and District Health Boards New Zealand (DHBNZ)[5,6] endorse the value of teamwork both to improve the quality of care through complementary disciplinary skill sets and to ensure workplaces are harmonious and supportive. Despite this apparent support, opportunities to undertake interprofessional education are limited in NZ. Where they exist, however, they are well accepted and commended by students and teachers alike.

In this paper we will outline the basis of interprofessional education, its relationship to interdisciplinary teamwork in primary care clinical practice, and describe a NZ model of postgraduate interprofessional education. Barriers to the implementation of interprofessional education in NZ will be identified as well as possible solutions.

What is interprofessional education?

Interprofessional education occurs when members from two or more professions associated with health or social service are engaged in learning with, from and about each other,[2] or a group of students from different health-related occupations with different educational backgrounds, learn together with interaction as an important goal.[7] It is an educational activity which uses interactive learning approaches[8] and puts a premium on innovative approaches to learning and teaching.[3]

However, interprofessional education is NOT different disciplines sitting together passively listening to the same lecture or listening to a lecturer of a different discipline from the students.[9] Neither is it professionals learning alongside each other but not engaging in dialogue regarding roles, contributions or disciplinary perspectives.[10]

Sue Pullon

***Sue Pullon** is a general practitioner, and **Eileen McKinlay** is a registered nurse. They are both Senior Lecturers in the Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences. Sue and Eileen teach and run programmes for undergraduate students and teach together in the interprofessional postgraduate programme. They have teaching and research interests in interprofessional learning, workforce development, and other clinical areas.*

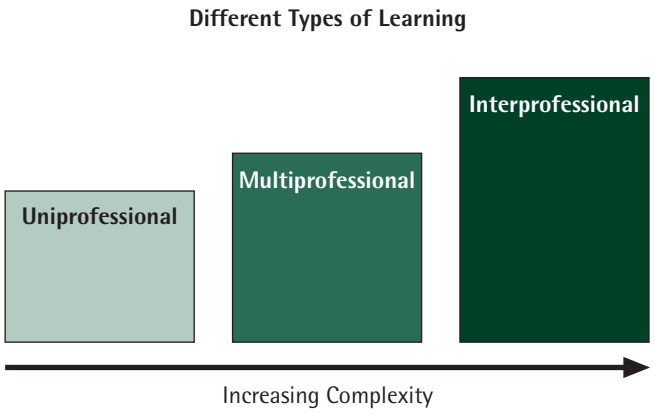
Eileen McKinlay

Why is interprofessional education different from other types of learning?

Interprofessional education differs when contrasted with other forms of learning because, although the focus is still on content, there is another level of learning about professional roles and interactions. As well as focusing on subject matter (generally clinical), students are actively challenged to critique traditional role definitions. Because of the dual focus, interprofessional education increases the complexity of the learning activity and outcome (see Figure 1).

In comparison, uniprofessional learning involves one discipline and is predominantly content or subject based, with little or no emphasis on interactional learning. Neither of these are to be confused with multiprofessional learning which involves members of more than one discipline, but disciplinary contributions, similarities and difference are infrequently discussed.

Figure 1. The different types of learning



What are the current learning opportunities for qualified primary health care professionals?

The different types of ongoing learning opportunities currently offered for qualified health professionals fall along a continuum (see Figure 2). The majority are uniprofessional (e.g. Continuing Medical Education , Continuing Nurse Education), some multiprofessional (Continuing Professional Development) but very few are interprofessional (structured interprofessional postgraduate courses, courses where interdisciplinary practice is integral to practice e.g. palliative care).

So, why do we value teamwork in clinical practice?

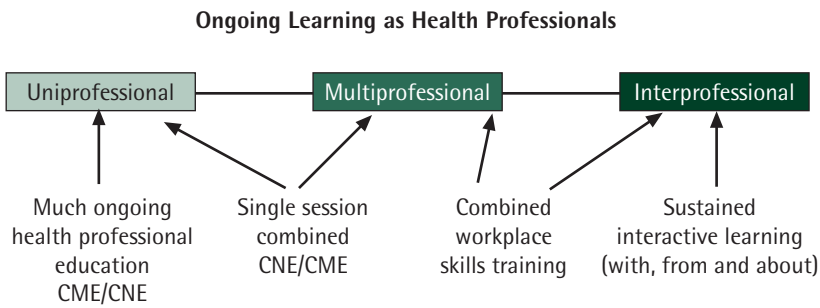
Effective teamwork in clinical practice leads to continuity of care, capacity to take a broad and comprehensive view of patients' problems, availability of a range of skills, synergistic working between providers via mutual support and reciprocal education, higher productivity, innovation because of cross fertilisation of approaches and skills and, finally, it prevents professional isolation.[11-13]

But, teamwork in clinical practice does not always work. A recent Health and Disability Commissioner's report highlighted poor interprofessional communication noting *'team work is critical'*[14] with an expert witness saying: *'it is likely that communication problems are system-wise and not confined to doctors and nurses...'*[14] A study by Pronovost found one-third of nurses unable to speak up in an interdisciplinary forum when they found a patient problem.[15] So why does poor teamwork occur when all disciplines have the best intentions at heart? Hall and Weaver describe how health professionals enter health care teams with preconceived maps of their roles based on their learned culture, beliefs and cognitive approaches. The type of unidisciplinary education most health professionals have undertaken results in poor understandings of each others' role causing stress, anxiety, conflict and ineffectiveness in the team.[16]

What is the link between interprofessional education and effective teamwork in clinical practice?

International research suggests interprofessional education results in effective clinical teamwork through enabling students of different disciplinary backgrounds to actively engage in learning designed to lead to collaborative problem-solving approaches, mutual decision making and teamwork.[9] Importantly it increases and enhances understanding of each others' professional roles and activities.[17] New Zealand research has found interprofessional education fosters *'...recognition by each healthcare worker of the strengths that other professionals bring to the clinical team, with respect for other members of the team and trust to allow open discussion...and translation of this discussion into action'*.[18]

Figure 2. Ongoing education for qualified primary health care professionals



Interprofessional education also values disciplinary difference. *'...it is not what people have in common but their differences that make collaborative working more powerful than working separately. Working together means that all participants bring equally valid knowledge and expertise from their professional and personal experience...but it is the questions and challenges that arise from the differences that are vital.'*[19] The quality of care provided by an effective interdisciplinary team counters recent thinking[20] advocating the introduction of generic health workers who have no specific disciplinary background. *'Multi-skilled, non-specific health workers though possibly able to undertake tasks more cheaply will not bring with them professionalism or the value of professional identity that team work maximises.'*[21]

Interprofessional education leads to collaborative clinical practice by building effective teams, establishing common values, knowledge and skills, fostering an understanding not only of students' own professional roles, but also enhancing understanding of others' roles. In doing this and critical to primary health care (PHC), it strengthens professional identities so that negotiation of work roles at the boundaries is successful and mutually respectful. This enhances the repertoire of knowledge, skills and attitudes of professional practitioners and responding to changing practice and changing professional roles.[21-23]

Table 1. Some examples of student feedback, interprofessional postgraduate programme, Department of Primary Health Care and General Practice, Wellington

Students have said...
'At a practical level, the course was very beneficial in helping us to work with people with chronic illness and to develop new approaches to care.' 'Every doctor should do this course.' *(Independent focus group evaluations, chronic illness management paper 2006)*
'Thank you once again for teaching this neat course. It has proved very challenging and I have learnt so much. I have also appreciated your openness and patient generosity. I kind of cringe when I think of some of my views going into this paper, compared to what I think now.' 'I just want to say thank you – I have enjoyed the course – you both gave good feedback and were open to questions which was great.' *(Students giving feedback at the end of the primary health care paper, 2007)*
'Tutors were genuinely supportive, worked together very well and generated a team approach.' ...commended the tutors' 'amazing commitment' to the course. The tutors were described as 'easy to talk to', 'very relaxed and supportive' and their teaching was seen to be of 'extraordinary relevance'. *(Independent focus group evaluations, primary health care paper, chronic illness management paper, 2005)*

A NZ example of interprofessional education

In the Wellington Department of Primary Health Care and General Practice, an interprofessional postgraduate programme has been developing and expanding steadily over the past nine years. Qualifications in primary health care, travel medicine and general practice offer advanced learning for doctors, nurses, pharmacists and other primary health professionals. The courses are delivered in flexible, distance learning formats that allow students to study while engaged in clinical practice anywhere in the country. Audioconferencing and use of asynchronous e-learning discussion boards support the face-to-face residential block component to enable students to interact with each other and teachers. Taught papers include NZ contemporary primary health care, Te Tuhauora: Maori health, sexual health, mental health issues, chronic conditions management, addictive behaviour management, travel medicine, tropical and migrant medicine, and wilderness medicine.

Content is targeted to the educational needs of the current workforce, so is constantly updated and changed every semester; e-learning allows these changes to be easily incorporated. Each year, regardless of discipline, all students follow the same course content and undertake the same assessments; academic achievement is impressive in all disciplinary groups. A variety of intentional activities using different technologies (e-learning platform, audioconferencing, face-to-face) foster reflection and support the practice of working in teams. The residential block courses held one or twice a semester are the highlight of every course; nurses and doctors, with a small number of pharmacists and health managers, welcome the chance to learn with, from, and about each others' work.

Over the nine years the programme has been running, the disciplinary mix has included about one-third nurses and two-thirds doctors, with total numbers increasing and the proportion of nurses steadily growing in the last three years. Nearly all students are working as full-time PHC professionals; either as general practitioners, practice nurses, or other primary care nurses, so their study is part-time, and often progresses slowly over several years. Five years to complete a diploma part-time is not uncommon. But students' commitment to primary care health service is huge, and often given as an important reason for undertaking study. Of the 250 or so students enrolling over the last nine years, about two-thirds have already completed a postgraduate certificate and/or diploma, and some are now progressing to complete master's qualifications.

In an earlier graduate survey,[24] students told us that interprofessional study specifically encouraged them

to stay in a sector they would otherwise leave (77% of nurses, 35% of doctors); and for most (88%) the interdisciplinary postgraduate study improved their own professional practice. But, just as importantly, for a majority, postgraduate study improved workplace practice (68%), and, for nearly half (45%), their study directly increased collaborative practice in their workplace.

This programme has shown that interprofessional education can be successfully applied in a whole variety of content areas, and is especially suited to those working in primary care. When programmes such as this one go well, the rewards are huge, not just for students but also for teachers, and even though challenging, it can be a lot of fun, and satisfying for everyone.

Barriers to the implementation of interprofessional education in New Zealand

Despite interprofessional education resulting in clinical teamwork and in turn improving quality of care, NZ primary care health professionals face significant barriers in accessing interprofessional education. Some barriers also affect secondary care colleagues such as the direct financial costs of fees, travel, Internet access, replacement of staff while studying and attending in-course requirements and little or no protected study time. However, in addition, for primary care health professionals there is lack of recognition, let alone active promotion of interprofessional education courses by professional organisations for accreditation, reaccreditation, and for validated funding via DHBs. What little funding there is, is dependent on this recognition. Sadly people tend to think a course, even one based in a university and mandated by the Committee on University Academic Programmes (CUAP), is not appropriate to undertake if not funded by a body like the Clinical Training Agency (CTA) or endorsed by professional bodies such as Medical or Nursing Councils.

Table 2. High level barriers to interprofessional education

Political
High-level policy supports ongoing professional development, collaborative practice, interdisciplinary teamwork, interprofessional education. But the MoH appears to promote interdisciplinary teamwork only in principle and it leaves implementation to chance. For example, those working in health recognise the integral nature of health and social welfare/social service yet there is no Ministry of Social Development involvement in any health related education
Organisational
Professional and other organisations are largely silent or pay lip-service to interprofessional education. Because their mandate, as membership organisations, is to represent a single disciplinary group, professional organisations have few mechanisms for recognising interprofessional education and few drivers for doing so. The clinical training agency (Vote Health) that has largely disbursed funds for uni-disciplinary vocational training. In particular CTA funding for clinical training has been largely directed at vocational training for doctors, with the bulk of funding monies going to secondary care training. For GPs, this funding has only provided for a single year of uni-disciplinary early vocational training for an inadequate number. For PHC nurses the very limited amount of funds that are available is disbursed through DHBs.
Educational
Few educational institutions offer interprofessional education. Educational institutions have limited drivers to offer interprofessional education as opposed to regular uni-disciplinary courses. Some tertiary education providers do offer interprofessional education for health professionals, but this is usually only because of individual staff initiative; student numbers remain small, making sustained course viability difficult.
Cultural
Increasing numbers of students are seeking out interprofessional education. But mistrust between professional groups can put some students off participating and mistrust between professional groups can put some tutors and institutions off developing and/or participating in interprofessional education.

New Zealand is not alone in this experience. In the UK, barriers to successful implementation of interprofessional education for postgraduate health professionals were noted to be: political, organisational, educational and cultural. Success and sustained delivery has been required not only to remove these barriers, but also organisational support and active promotion.[3]

Within NZ, separate government funding streams, such as Vote Health, Education or Social Development results in a lack of cohesion when considering health and social services postgraduate education needs. In turn, separate disciplinary regulatory councils, as well as the various Colleges further fragment this together with a final layer of tertiary and other education providers, District Health Boards, Primary Health Organisations and Management Services Organisations.

These funding barriers also work in concert with other high level barriers outlined in Table 2.

The solutions – high level change is needed

A report to the Minister of Health in 2006 on quality in health care stated: *'In the past most training and education in health care has been delivered and governed from within each specific discipline. This mono-discipline approach does not match the delivery of health care approaches where interdependence, complexity and technology are the norm. Not only do health workers require an in-depth understanding of their own specialty*

they must also know how to work in teams and how to improve the processes within which they work."[5]

Despite these recommendations and those of the now dissolved Health Workforce Advisory Committee,[25] nothing has changed to address the barriers at different levels.

A number of solutions are required which, if implemented together, would enable increasing interprofessional education opportunities:

- Formation of a single national organisation to promote and manage integrated workforce planning and education, both interprofessional education and uni-disciplinary education, with representation from professional organisations and education institutions.
- All professional organisations should have to facilitate and promote interprofessional education at postgraduate level, by requiring a proportion of interprofessional learning for accreditation, reaccreditation and HPCA professional development requirements.
- Vote Education and Vote Health should both contribute to educational funding streams for postgraduate education, especially for the primary care workforce.
- DHBs and PHOs should be required to support ongoing education, but not necessarily provide it.
- Tertiary education providers should have to provide interprofessional education options for health professionals, at least at postgraduate level, if not at undergraduate level.

Conclusion

Interprofessional postgraduate education provides experienced PHC professionals subject content and enables enhanced interdisciplinary practice back in the workplace. The Department of Primary Health Care and General Practice, University of Otago have developed a distance learning interprofessional education programme which is a pragmatic solution for busy PHC health professionals who wish to upskill and foster interdisciplinary skills. Distance learning interprofessional education uses a variety of technologies and intentional processes to build interdisciplinary practice despite limited face-to-face time. In NZ, despite health authorities advocating clinical teamwork and interprofessional education, a variety of structural and attitudinal barriers challenge the development and practice of interprofessional education. Solutions proposed included formation of a national body with oversight for all health education pathways (including interprofessional education and uni-disciplinary) as well as financial and other support from appropriate government bodies, regulators, professional organisations, DHBs and tertiary providers.

Competing interests

None declared

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