Change processes in Interprofessional Collaborative education and -practice in Health Care

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Abstract

The public health sector in welfare states is increasingly subject to organisational changes, and collaboration between healthcare professionals has long been requested as a way to obtain higher quality and at the same time lower spending in health care. In addition, it has been welcomed as a way to equalize power relations among healthcare professionals. However, many critical perspectives on collaborative practice have emerged over the past. Based on desk research, we investigate the various ways collaborative practice historically has been defined and understood to integrate the knowledge development about collaborative practice into its current state. We find that a broad range of definitions and normative concepts has been proposed. We demonstrate that the various definitions lead to different directions of organising work. We conclude that whether and in what sense a focus on collaborative practice can be said to help improve the delivery of health care depends on the context, the agendas and interests of the involved actors.

Keywords

interprofessional collaboration, collaborative practices, professions, interprofessional education, public health sector, collaborative learning

Introduction

Whereas the roles and role boundaries of healthcare professions have always been dynamic, incitements to create and sustain new interprofessional identities and cultures are more recent and notably, global. For example, the ability to collaborate is touted in internationally acclaimed reports (WHO, 2010; Frenk et al., 2010) as the solution to future healthcare challenges such as diminishing resources, an ageing population and workforce, and advancements in medicine that enable people with complex healthcare problems to live longer, requiring more care. The ability to collaborate is thus increasingly considered a basic competency for healthcare professionals. However, as Bode et al. (2016) have shown, the work of bringing the 'tenacious' professional bureaucracies in the healthcare sector under more comprehensive control is difficult. One of the reasons is that in a

hospital context, knowledge is standardized in a hierarchy of evidence. So what does it mean to collaborate in healthcare practice and is interprofessional collaboration possible? In this paper, we critically review the literature to provide a historical overview of IPE as an educational intervention. We ask: How has collaborative practice evolved over time discursively? What can we learn from the past and present forms of collaborative practice that we can apply when designing future forms of education for collaboration?

On the basis of a desk research and using well-established concepts of profession, identity, culture, and training/work transition, we critically look at the historical background of contemporary ideals about collaborative practice in order to answer our research questions. We inquire the ideological impetus of interprofessional education and –practice. This will be followed by a section, where we focus on the various theoretical frameworks applied during time. Here, we will demonstrate how education is considered as the predominant determinant for collaborative learning. Our focus will also be on how professional identity and culture is understood in the studies. In our discussion section, we point at the lack of reference to the fundamental structures of socio-economic inequality upon which educational, social and above all, health inequality rest.

Preliminary Findings

The work of Hammick et al. (2009) is an example of a perspective of proponents of collaborative practice. To them, being interprofessional is integral to professional identity:

> ...to indicate that what we are discussing concerns about how we are, how we act, and what we do in our professional and working lives. The word indicates that being interprofessional is, or should always be, part of our professional lives. Ideally, being interprofessional is a routine and regular part of how we work, an active rather than passive-related behaviour (p. 8).

Furthermore:

> Being interprofessional means that we:Know what to do... This is often referred to as knowing the right thing to doHave the skills to know what should be done: This means being competent and capable of behaving and doing things correctly. Conduct

> ourselves in the right way when carrying out a particular action. This involves doing the task with the appropriate attitudes, and having suitable values and beliefs about what we are doing. (pp. 8-9)

Another recent and very central player in relation to offering a collaboration - solution to the new challenges of hospitals is the American researcher is Jody Hoffer Gittell (2002, 2016). Based on her research within the US aircraft industry and hospital sector, Gittell has developed a management system that she calls relational coordination (RC), which she defines as a 'mutually reinforcing process of interaction between communication and relationships carried out for the purpose of task integration' (Gittell 2002, p. 301). What is new here is that she focuses on the relationships in the work through an explicit focus on coordination and cooperation between the professional groups. Experiences from American studies show that there is a clear correlation between the quality of treatment and admission time and the quality of the relational coordination. According to Gittell, higher efficiency can be achieved if you have common goals, share knowledge, and have mutual respect for each other. In addition, a feature of RC is, according to Gittell (2016, p. 1702), that it can contribute to the psychosocial well-being of the hospital staff in a situation where they – in a context of demands about productivity – would otherwise feel pressured.

Closely related to RC is a system developed in Canada called interprofessional education (IPE) and interprofessional practice (IPP). Behind these concepts lies the desire for a democratic professional practice based on an understanding that the problem for the healthcare system is that the group of health professionals cannot or will not cooperate (Axelsson & Axelsson 2009). D'Amour and Oandasan (2005, p. 9) provide the following definition of interprofessional learning and cooperation: 'interprofessionality is defined as the development of cohesive practice between professionals from different disciplines' and further that 'interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working'. The intention is, therefore, to promote a coherent and inclusive practice between the healthcare system's users, the different professions, and sectors, as well as strengthen mutual professional recognition and respect amongst equal partners. This is done by promoting a

particular set of values and way of being an employee and colleague.

IPE has become a core curricular component in many health professions' international education programmes where it is introduced as an effective evidence-based method for establishing continuity of patient care (Gittell, Godfrey, & Thistlethwaite, 2013). However, IPE is often criticised for being under-theorised and lacking explanations to understand why certain approached to IPE succeed or fail (Paradis and Whitehead 2018; Reeves et al 2017). According to Paradis & Whitehead (2018), there has been three historical "waves" of IPE. The first wave focused on managing the health workforce through shared curriculum. This was followed by a wave where the discourse aimed at maximizing population health through health workforce planning. Presently, we see a wave that aims at fixing individuals to fix health care.

When considering more recent studies, we will highlight a Swiss conceptual study of what they call Interprofessional Collaboration (IPC), Schmitz et al (2017) where different organisational contexts (primary care, surgical care, internal medicine, psychiatric care, and palliative care) were explored in order to understand, what IPC meant for practicing professionals concerning successful interprofessionalism. The study was carried out as qualitative interviews with various healthcare professionals. In their study, they found three forms: A) Coordinative collaboration where collaboration is based on learned skills situated within a medical rationale. B) Co-creative collaboration, which means that various professional skills are combined concurrently and successively over extensive timeframes. C) The third form i called ad hoc or project-like collaboration shows in practice when recurrent problematic situations are needed to solve. The study concludes, "The question of whether and how IPC occurs, and is perceived by the participants as successful or unsuccessful, strongly depends on the context or settings in which these health professionals work." The authors find this an interesting finding, because it is often assumed that IPC is driven by individuals, by teams, by educational programmes, profession interests, or by management goals. The authors stress the meaning of the context and setting as the most important in constituting the practical implementation and the subjective perception of IPC.

A similar conclusion is made in a Danish study of collaborative practice (IPP) in public hospitals. On the basis of interviews with healthcare professionals at three large public hospitals where the focus was on how IPE and IPP was translated into practice. Hindhede & Andersen (2019) found that professional stereotypes were reinforced through IPE activities, as both nurses and doctors emphasized that the strengthening of mono-professionalism was the goal of their collaborative practice, which thus affected how they translated the concept to practice. For nurses, though, the focus on mono-professionalism was considered helpful, as the tool led to them being recognized as a group of people whose voices are heard in interprofessional teamwork. Their analyses show how a gap occurs between the social production of knowledge about interdisciplinary cooperation in terms of measurable tools and the social experience of interprofessionality and cooperation around the patient amongst the different professional groups in the hospitals. They argue that this gap creates an interpretive space for both understanding and action.

In a recent book on collaborative practice in primary and community care, Ahluwalia, Spicer, and Story (2020) conclude that despite a shared educational mission and common vision as espoused in curricula to enhance patient care, collaborative work can be hard to achieve. Some of the reasons for this relates to organisational and structural issues We address these organisational and structural issues in more detail in the last part of our analysis.

Conclusion

We conclude that to truly understand the meaning of collaborative practice, one must have a historical understanding of the changes in the concept and how it has evolved to reflect present beliefs and scientific understanding of health care practices. Our desk research summarizes the changes in the definition of collaborative practice over time in order to provide a context for the definition needed today.

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