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Commentary
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Interprofessional education in clinical practice: not a single vaccine

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Abstract. In increasingly complex health service environments, the quality of teamwork and co-operation between doctors, nurses and allied health professionals, is 'under the microscope'. Interprofessional education (IPE), a process whereby health professionals learn 'from, with and about each other', is advocated as a response to widespread calls for improved communication and collaboration between healthcare professionals.

Although there is much that is commendable in IPE, the authors caution that the benefits may be overstated if too much is attributed to, or expected of, IPE activities. The authors propose that clarity is required around what can realistically be achieved. Furthermore, engagement with clinicians in the clinical practice setting who are instrumental in assisting students make sense of their knowledge through practice, is imperative for sustainable outcomes.

In an increasingly complex health service environment, the quality of the teamwork and co-operation between doctors, nurses and allied health professionals, is 'under the microscope'. An imperative to create good working relationships that are based on teamwork and co-operation between different healthcare professions has arisen following international inquiries, such as Bristol, where the existing healthcare processes clearly failed the consumer.[1]

As a response to widespread calls for improved communication and collaboration between healthcare professionals, the concept of interprofessional education (IPE) has evolved. In the most widely cited definition, IPE is a process whereby health professionals learn 'from, with and about each other' (Centre for Advancement of Interprofessional Education, see www.caipe.org.uk/, accessed 14 September 2009). Interprofessional learning (IPL) and practice that in ideal circumstances is forthcoming from IPE is promoted as a means of facilitating effective communication, collaboration and teamwork within healthcare settings to improve patient care and student clinical learning outcomes.[2,3] As a result, IPL is increasingly viewed as a desirable curriculum component in health professional student education by both government and universities.

In several countries, interprofessional curriculum development and implementation has been supported by a coordinated, high level policy-driven, response to identified healthcare deficiencies. In contrast, in Australia, the process of interprofessional curriculum development and implementation is better characterised as a range of grass roots activities, often with a rural base.[4] Until recently there has been little general discussion or debate around the merits of IPL in an Australian context, or the need for national policy.[5,6] The concept of IPL as a means to improving both healthcare and student learning in Australia though is now back on the agenda.[6]

There is considerable momentum building around IPL in Australia with a wide educational, health service and political base. The attendant enthusiasm has heightened expectations regarding outcomes that might be expected from IPL initiatives. As a consequence, there is a real risk that benefits may be overstated and IPL become the answer or 'cure' to many current healthcare quality and safety concerns.

The viewpoint expressed in this paper is that the commitment, energy and enthusiasm embraced in developing and implementing interprofessional curricula may eventually result in disillusionment if too much is attributed to, or expected of, such activities. It is

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essential, therefore, that the key objectives of IPL in an Australian context are defined and supported by clearly articulated policy. A clear policy framework is necessary so that the goals of IPL are not confused with other healthcare agendas and that the rationale and realistic benefits of IPL are promoted. This discussion situates IPL in the health practice landscape in Australia and considers the scope of its potential contribution to clinical education in practice contexts as opposed to classroom based activities.

IPL and health service environments

How and what students learn, including what students learn about interprofessional practice, is largely dependent on the practices of their clinical discipline staff.[7] Facilitating learning across and between professional groups, although a cornerstone of IPL, can be counter productive if patient flow systems, healthcare processes, and educational structures do not support and reinforce interprofessional student engagement during the clinical experience.

The clinical placement in hospitals or other healthcare services provides the opportunity for students to make sense of their academic knowledge and to practice their clinical skills through observation of, and participation in, discipline-based clinical activities. Although doctors, nurses and allied healthcare professionals share a common commitment to quality patient care and effective teaching of students, in clinical settings, most professional disciplines largely work in isolation.[8,9] It can be difficult therefore for students to reconcile a theoretical knowledge of IPL with their clinical experiences of healthcare delivery if such understandings are not fully grounded in the reality of everyday clinical practice.

Healthcare services are complex environments that bring together a range of clinical professionals with rich, varied and deeply embedded approaches to practice and teaching. Even though in clinical settings students may be co-located with students from other health disciplines, there is usually little cross-disciplinary interaction during clinical activities. There are also differences in both structure and focus in the ways that discipline groups organise student learning that further reinforce individual discipline identities. There are many good reasons for such differences and future development of IPL initiatives should ensure the importance of this diversity is acknowledged.[10]

Meaningful IPL

Interprofessional education and learning has been linked to improved teamwork, enhanced quality care, greater patient participation, and improved patient outcomes, although the evidence for the latter is weaker.[11] The reality is that theoretical learning alone will not contribute to these outcomes as much as actual practice. Recognising that there is much to be gained in working towards IPL within clinical settings from both within medical, nursing and allied health programs as well as across these professions, we propose two goals.

First, the key objectives of IPL in Australia should be defined to allow a coordinated response to policy and delivery model development. Once identified, these key objectives should be actively promoted in the workplace so what can be achieved from IPL is clearly delineated and it is not seen as an 'all encompassing' end in itself or driver of particular healthcare agendas. Second, IPL should be underpinned by authentic clinical activities to ensure alignment between learning objectives and clinical learning experiences.

Identifying the key objectives of IPL

There is a pressing need for sector-wide dialogue in Australia about identifying the key objectives of IPL so that expectations can be managed regarding what it can and should deliver. As part of this dialogue, the full extent of existing understandings of what IPL is, and what it should be, would be canvassed together with an exploration of existing assumptions regarding where student learning might occur. Clearly articulating both specific learning objectives and where IPL should sit within the clinical learning experience is necessary to facilitate development of activities for students that are realistic and achievable. To avoid tokenism, IPL activities should be strategically embedded in everyday activities.

IPL within authentic medical, nursing and allied health practice

Clinical relevance will be central to the success of any IPL initiatives. IPL will be difficult to sustain if it sits apart from the routines and practices of the healthcare context in which it is situated. Although positive outcomes have been documented in terms of student IPL and awareness of patients' experience of healthcare in controlled, demonstration IPL wards overseas, students are wary of the extent to which this learning is transferable to the 'real world' and some dismiss it as 'not relevant to future practice'.[12]

Further development and implementation of IPL initiatives would benefit from doctors, nurses and allied health professionals identifying for students the contribution of their professional roles to patient care, and interactions that facilitate reciprocal learning with other health disciplines. Incorporating IPL concepts into existing clinical activities such as team conferences and ward rounds would enhance relevance to both students and clinical teachers. Interprofessional interactions could then be coached from the perspective of each profession (and, as with all effective teaching and learning, supported by successful modelling).

Limitations to many current approaches to teaching where IPL activities are not undertaken in authentic clinical settings have included a lack of transferability of IPL knowledge, skills and attitudes from the 'classroom' into the 'workplace'. In addition, because many IPL activities are artificially constructed, there is an increased risk of 'burn out' in clinical teachers because IPL becomes an additional activity that is increasingly complex in its execution.[12] Embedding the key objectives of IPL as a routine part of normal clinical activity is therefore much more likely to see IPL outcomes transferred into practice.

Conclusion

IPL is not a vaccine against all health system ailments. Rather it offers further opportunities to enhance student clinical learning and achievement of knowledge, skills and attitudes that will be needed for high quality patient care into the future.

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