

Interprofessional learning and practice can make a difference

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In their editorial in a previous issue of the Journal, Piterman and colleagues¹ question whether interprofessional education for interprofessional practice among the health care workforce makes a difference.

Interprofessional education (IPE), learning (IPL) and practice (IPP) *can* make a difference.² We base our claim on findings from a large-scale longitudinal study across an Australian health jurisdiction.² This study revealed that learning and practising in a collaborative interprofessional team promotes a reflective practice environment that can generate and encourage shared knowledge. Success becomes self-reinforcing as clinical relationships are refashioned.³

Among the elements of collaborative interprofessional practice are a commitment to power sharing, distributed leadership and striving for teamwork. Our research has identified that some of the key determinants to achieving greater levels of interprofessionalism are: establishing the right environmental conditions; having champions; overcoming perceptual and organisational silos; working to improve health care relations; and collectively conducting quality and patient-safety initiatives.³⁻⁵ Interprofessional collaboration has been shown to improve teamwork and reduce clinical error rates.⁶ The alternative to this can no longer be supported.

Learning must be considered not merely as formal education but in terms of its relationship to practice, a point evident in Piterman et al's definition of IPE.¹ Formal education is not necessarily learning; people learn mostly by practising.

Piterman and colleagues argue that there is much rhetoric about, and limited evidence for, interprofessional collaboration.¹ The evidence base in this field is more developed than is acknowledged by its critics, with a range of literature describing the association between IPL and IPP and quality of patient care, health outcomes or teamwork.^{4,5,7-10} In 2010, Australia hosted an international IPP conference which attracted over 400 academic and health practitioners,¹¹ many of whom reported associations between IPL, IPP and improvement in patient care.

Australia is showing leadership in the field of health interprofessional collaboration. Since 2007, we have been examining how IPE and IPL support IPP within the Australian Capital Territory health system.²⁻⁵ Australia is the only country to have undertaken such a study, aiming to understand systems-wide change. To our knowledge, our collaborative partner in this action research, ACT Health, is the first health agency to embed the principles of and structures for interprofessional collaboration across its workforce. Over the past 5 years, ACT Health has implemented a number of strategies to this end, including nominating an executive sponsor for an organisational IPL program; developing and instigating an organisational policy for the program; conducting seminars and training in IPL and IPP; developing a strategic plan for IPL; and collaborating with universities to examine opportunities for practice simulation.¹²

The challenges and barriers to implementing and improving interprofessional collaboration, as noted by Piterman and colleagues,¹ are numerous. System barriers, such as mechanisms for funding or organising health care, are also recognised as impediments to change and innovation in health services. To these, we

ABSTRACT

- Interprofessional learning and practice can be positively self-reinforcing and can promote improved care.
- Australia is showing leadership in the field of interprofessional collaboration.
- Changing attitudes to interprofessional collaboration is a key to improving health care. Implementing interprofessional collaboration requires a multifaceted approach, and research to underpin it.

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would add what we consider to be an underlying and significant barrier — the resistance to change of some academics and health professionals.^{10,13,14} This should not be surprising. Achieving attitudinal and practice change is one of the greatest challenges in health care. The lack of progress in advancing interprofessional collaboration strongly suggests that academic and health professionals do not yet accept that interprofessionalism will enable “improved ... coordination of health services, better use of specialist resources, and improved health outcomes ...”¹ When they more widely accept that such benefits could be provided through interprofessional collaboration, then perhaps we will reach a tipping point. The introduction of incentives may assist in moving us closer to a change in attitudes and behaviour; so might the mandating of interprofessional collaboration for individuals and organisations by registration and accreditation bodies. We wholeheartedly agree with Piterman and colleagues on the need to advance IPL initiatives.

However, research in this area, like much in the quality field, is not about demonstrating causality as sought by randomised controlled trials (RCTs). RCT methods cannot be deployed by those of us investigating the naturalistic interactions of learning and practice. By definition, the issues and questions that need to be examined occur in complex organisational environments involving diverse participants with a multitude of influences. The interaction of complex agents cannot be analysed within the structure of an RCT.¹⁵ Studies seeking to track measurement of progress and understand what determines effectiveness are required.¹⁶ To this end, realistic evaluation and quasi-experimental or interrupted time series trials are methods that can be used to evaluate the impact of learning and practice changes in complex evolving environments. We believe that it is necessary to develop rigorous research studies appropriate for the questions that need to be examined, rather than being fixated on a particular research approach.

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Competing interests

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