Interprofessional education for interprofessional collaboration—
Where should we go from here?

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Map of Our Journey

- Review the three waves of interprofessional education (IPE), with examples and critiques
- Discuss the features of a potential “fourth” wave of IPE or education for collaboration.
Learning Objectives

After the session, audience members will be able to:

1. Describe some of the reasons why an early IPE intervention in Vancouver, Canada, failed
2. Describe the features of contemporary models of IPE at the University of Toronto, Canada
3. Explain some of the key limitations of current versions of IPE, from a social science perspective
4. Make suggestions for improving IPE and maximizing its impact.
IPE “occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE 2002).
Three waves of Interprofessional Education (in Canada)
Annual count of IPE-related articles (WoS + PubMed)
First Wave of IPE
1959-1979, in Vancouver, Canada.

In this article, we asked:

How was IPE promoted, received, by whom, for what purposes, in what forms and to what effects at the University of British Columbia (UBC)?

The UBC IPE experiment

• Was an answer to local and national challenges
  – The need for a new Health Sciences Centre @UBC
  – Canada’s new public health system: increased need for primary care and better management of supply

• Was led by a powerful and well-connected leader, Dr. John McCreary. He penned and articulated the IPE vision with his medical colleagues, and set himself to convince his interprofessional peers to join in.
The UBC IPE experiment

A major tension arose: it was unclear whether IPE’s **purpose** was to support and encourage a vision of all health professions as

- Unique contributors and experts in their own domain? Or as

- Substitutes or aides to medicine and physicians?
The UBC IPE experiment

In the end, the UBC IPE experiment failed because

- McCreary failed to convince the other professions that it was in their best self-interest to join into the IPE vision

- It didn’t garner the continued financial support of stakeholders.

The Division of IPE was closed in 1975, soon after McCreary retired (1974; d. 1979).
Second Wave of IPE
Western Countries, 1994-1999

- Focused on better workforce management
- Anchored in the belief that it is lack of knowledge that limits professionals’ ability to collaborate.
- The goal of IPE, then, was to provide students exposure to other students’ roles, which will naturally lead to integrated and higher-quality care.
Third Wave of IPE
Third Wave of IPE, 1999-

- Overshadowed the second wave
- Now a global concern
- Rides on the coattails of the patient safety movement (Institutes of Medicine, 1999: *To Err is Human*)
- Suggests that IPE will help curb errors, improve patient outcomes and satisfaction, and prepare clinicians for the needs of our complex healthcare system and the complicated needs of our aging patients.
Annually, the Centre for IPE manages 1,600 new students from 11 Health Science Programs:

- Dentistry
- Kinesiology and Physical Education
- Medical Radiation Sciences
- Medicine
- Nursing
- Occupational Science and Occupational Therapy
- Pharmacy
- Physical Therapy
- Physician Assistant
- Social Work
- Speech-Language Pathology.
3 developmental levels

- Exposure
- Immersion
- Competence
The Curriculum

4 Core Learning Activities
1. Teamwork: Your Future in Health Care
2. Conflict in Interprofessional Life
3. Case-based Pain Curriculum (950 students)
4. IPE components in Clinical Placements

2 Elective Learning Activities
Based on students’ choices.
Component in clinical placement

1 of the following:
- Structured Placement
- Participation in IPE
- Interviewing/Shadowing Team Member
- Participation in Team Meeting
The Centre for Interprofessional Education

- Receives funding from 11 health sciences faculties from the University of Toronto, as well as moneys from the University Health Network
- Supports several full-time staff members and part-time scientists
- Coordinates placements across clinical sites
- Works with an interprofessional student association.
3\textsuperscript{rd} wave falls short


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It is still unclear whether IPE should be implemented at the undergraduate, postgraduate or practice level.


On the one hand, many scholars believe we should socialize students early into a more collaborative, “healthcare team” identity.
On the other, scholars argue that it is impossible for preclinical students to engage in the core activities of IPE – including role discussion and negotiation – when they do not know their future clinical role.
IPE might be developmentally inappropriate, and set our students up for disappointment (if not failure).
Undergraduate-level models of IPE train students to expect collaborative work environments, yet students and young graduates often confront a reality that is …
As newcomers in an inertial system, they are rarely in positions to confront harmful and unsafe professional hierarchies.
IPE has been widely criticized for being atheoretical and ahistorical.


Yet its model of “learning with, from and about other healthcare professionals” hinges implicitly on contact theory.
What is contact theory?
This theory suggests that bringing members of different groups together should reduce prejudice and improve intergroup relationships.

A recent review of the literature provides support for contact theory, but suggests that

1. Individuals who are “coerced” into intergroup interactions often experience negative contact.

2. Positive intergroup contact requires equal status among participants.

This is distressing news for IPE
… as it both coerces students into intergroup interactions AND is not designed to equalize status among participants.
Indeed, a growing corpus of critical IPE research hints at both the reinforcement of professional stereotypes among students and at the widespread frustration with IPE’s tacit acceptance of the hierarchy of professions.

Enabling contact among healthcare professionals is not enough; had it been, their history of delivering care together would arguably have ironed the kinks out of collaborative care.
We desperately need to anchor education for collaboration in a more robust theory of how the professions actually come together.


IPE aims to improve patient care outcomes by educating collaboration-ready professionals who can transform healthcare delivery.
It is absolutely reasonable to expect an educational intervention such as IPE to change the attitudes and beliefs of students, although…
The larger claim that IPE can actually change healthcare practices rests on very fragile grounds.
A systematic review covering 30 years of IPE research found only 15 studies that met inclusion criteria. The authors wrote that “it is not possible to draw generalisable inferences about the key elements of IPE and its effectiveness.”

Moreover, the WHO (2013) found “no practice-level impact assessment” of IPE on patient care, and consequently recommended implementing IPE “only in the context of rigorous research.”

Lack of evidence about IPE’s effectiveness is *not* proof of ineffectiveness, and educators know that documenting the impact of educational interventions is extremely hard.
But what if we stopped assuming that undergraduate IPE is the key to education for collaboration, and we started looking elsewhere?
What is the problem that IPE is trying to solve?
Power, hierarchies, conflict, and their consequences.
To what extent are these issues described and addressed in the IPE literature?
2,191 IPE-related articles (WoS, PubMed)
We found that only 6 of the 2,191 articles actually discussed sociological rather than statistical power.
If issues of power are known and recognized in clinical practice and in the IPC literature, why then does the IPE literature fail to address them?
Failure to engage power positions IPE as a solution to an amorphous and unarticulated problem. By ignoring power and conflict, the IPE literature obscures what exactly it is that the IPE initiatives are (theoretically) aiming to correct.
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IPE requires a “significant layer of coordination” to be developed and implemented successfully.


The literature fully acknowledges these pragmatic constraints and their negative impact on IPE, both in terms of the quality of the offerings and of the educational experience.
But it never considers abandoning the boat, in the hopes that one day the right mixture of “ingredients” will solve all of IPE’s problems, including its logistical nightmare.

Developmentally inappropriate
Developmentally inappropriate

Violates its core assumptions
Developmentally inappropriate
Violates its core assumptions
Missing link to patient care
1. Developmentally inappropriate
2. Violates its core assumptions
3. Missing link to patient care
4. No attention to power
1. Developmentally inappropriate
2. Violates its core assumptions
3. Missing link to patient care
4. No attention to power
5. Logistical nightmare
Where should we go from here?
Fourth Wave of IPE
A 4th wave of IPE might provide a more productive way forward.
The 4th wave should learn from the past

- Build initiatives interprofessionally rather than seeking buy-in for pre-determined vision
- Develop allies and the funding necessary to stabilize programs
- Express goals in terms of local and national priorities
- Make sure learning objectives and activities are developmentally appropriate
- Consider that healthcare is an inertial system, and develop a strategy to change legal, organizational and cultural impediments to collaborative care delivery
The 4th wave should learn from the past

- To maximize the potential of interaction (contact theory), avoid coercion and equalize status among professionals during activities
- Focus your attention on practice contexts
- Tackle issues of power and conflict directly
- Simplify the structure of IPE curriculum and use resources to support content and activity development.
Two concrete suggestions
Uniprofessional education for collaboration that is...
Developmentally appropriate
Theoretically grounded
More likely to impact care
Pays attention to power
Logistically straightforward
Since collaboration is a core educational outcome for many competency frameworks, its teaching is part of the educational mandate of many clinical faculties.
By focusing on where we want to bring our students we can develop a curriculum that is scientifically sound and meets professional objectives.
Then, we could ground education for collaboration where it has the greatest likelihood to impact and transform care delivery:
On the ground. In practice settings.
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