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Interprofessional Working and Continuing Medical Education.

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Education And Debate Continuing medical education

Interprofessional working and continuing medical education

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Editorial by Toghill

The increased focus on the results of professional practice (that is, the health outcomes of individuals and populations) creates two related tensions which will be considered in this paper. The first is the need for improved working and collaboration among different health professionals; the second is the demand for a broader vision of continuing medical education (CME).

Almost everyone who seeks medical care interacts with more than one health professional. The number of professionals involved and the importance of their ability to work collaboratively increases with the complexity of the patient's needs. New initiatives to improve management of diseases such as asthma, diabetes, or congestive heart failure invariably point out the need for interprofessional collaboration.[1] Increasingly, the “myth of the omnipotence of the independent practitioner” is being challenged as we discover the gains in quality and savings in cost when health professionals work together well.[2]

At the same time, traditional approaches to delivering CME for doctors are being questioned. A recent review of randomised controlled trials of CME concluded that it was undermined by difficulties with its delivery, that it seemed unable to respond to the urgent demands of healthcare reform, and that there was little evidence for its own effectiveness and efficacy.[3] The bulk of the studies focused on traditional approaches, although they identified a widening range of CME activities. Further, it was shown that even when there was change in doctors' behaviour there was “most often a small, less often a moderate, and rarely a large” effect on health outcomes.

In its working paper *Continuing Professional Development for Doctors and Dentists*, the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) concluded that “conventional continuing medical education is no longer adequate to meet all the education and career development needs of doctors in modern health care.”[4]

It argued that CME needs to be set in the wider context of continuing professional development. While updates of clinical knowledge for individual doctors remain important, other learning is needed, including strategies for multidisciplinary and multiprofessional working. (Although the SCOPME report speaks of multiprofessional learning, the term “interprofessional” has since gained favour. For many, “interprofessional” better reflects the need for dynamic interaction among professionals to ensure that learning goes beyond merely having members of different professions sharing the same classroom together.)

Summary points

Greater focus on results of professional practice creates a need for improved collaboration by medical professionals and a broader vision of continuing medical education

Effective interprofessional working ranges from loosely coordinated collaboration to closely organised teamwork. Across this range, certain key elements increase the likelihood of success

Shared goals around patients' needs, and an approach focus in on processes that serve that need, can help transcend traditional barriers

Effective adult learning occurs when the topic is important to the learner and when learning combines reflection with concrete experience

Making interprofessional collaboration and teamwork a reality

Interprofessional working can be thought of as a spectrum, with more loosely coordinated efforts of collaboration at one end and more tightly organised work of teams at the other. Most doctors and other health professionals are required to work at multiple points on the spectrum (perhaps even within the same day), depending on the nature of the needs at hand. West described the characteristics of good interprofessional collaboration[5]; not surprisingly, they are similar to the requirements for good teamwork. This is shown in the box at top of p 772, which compares the attributes cited by West with the literature on successful teams, both in and out of health care.[6–12]

Characteristics of high quality interprofessional collaboration and teamwork

Collaboration5	Teamwork
	Direction is clear 9 11
Attainable, evolving shared vision	Mission is engaging and motivating 7 9 11
Goals and objectives are stated, restated, and reinforced 6 8	
Member roles and tasks are clear and known 6 9 11 12	

Collaboration5	Teamwork
Clear, shared objectives	Atmosphere is respectful6
Mutual support	Responsibility for team success is shared among members 6 7 9 12
Member participation is balanced appropriately to task at hand 11 12	
Conflict is acknowledged and processed 6 11 12	
Goals fit organisational goals 7 9 12	
Effective participation	Task is achievable 9 12
Clear specifications regarding authority and accountability7	
Decision making procedures are clear and known 6 12	
Task orientation	Communication and information sharing is regular and routine 6 9 11 12
Enabling environment, including access to needed resources 7 9	
Ongoing testing of assumptions12	
Information and appropriate management structures	Mechanism to evaluate outcomes and adjust accordingly6
Support for innovation	

The table in the box lists a variety of elements that contribute to skilful and effective work across the "interprofessional working" spectrum. For example, without a clear objective, any group's efforts are less likely to succeed.[7] In health care, agreement regarding goals often emerges when the patient's needs become the explicit focus.

Figure1

Health professionals tend to work autonomously even though they may speak of being in a team.[13] Common barriers to effective interprofessional work are well known and summarised in the box on p 773. [6 8 11 14] They range from fears of diluted professional identity to differences in schedules and professional routines. Physicians and other professionals face increasing accountability for the results of their work, but the health professionals caring for the same group of patients often are employed by different organisations and may be held to different standards. Since the introduction of general management the tensions between corporate working and individual clinical freedom have become a factor. Researchers discuss the importance of selecting a team with the right balance of skills and personalities,[7] but the reality of practice is often that the professionals with whom one must collaborate are the people who happen to be there. Given these challenges, how can we create professional development that will foster the interprofessional collaboration and teamwork needed for improved practice?

A place to start is the fact that most health professionals have at least one characteristic in common, a personal desire to learn, and that they have at least one shared value, to meet the needs of their patients or clients. Alongside this is the understanding that adults learn best when the topic at hand is geared closely to their interests.[15] Further, they learn best experientially, deriving for themselves abstract concepts from their own concrete experience and then testing these concepts in new situations.[16] Those who are no longer beginners are frustrated by theory based discussions of rules that have no context.[17]

Improved health outcomes usually lie outside the scope or control of any single practitioner. Real improvements are likely to occur if the range of professionals responsible for providing a particular service are brought together to share their different knowledge and experiences, agree what improvements they would like to see, test these in practice, and jointly learn from their results. [18 19] As they build their knowledge about how things currently work, such groups are likely to discover that their difficulties are more often derived from the processes they use than from each other. A recent study in Oxford showed that one consequence of establishing multiprofessional improvement teams in general practices was increased collaboration and focus on planning and strategy within the practices.[20] A powerful incentive for greater teamwork among professionals is created by directing attention to the areas where changes are likely to result in measurable improvements for the patients they serve together, rather than concentrating on what on the surface seem to be irreconcilable professional differences.

A patient interviewed on the radio recently declared that the NHS needed “joined-up thinking”; perhaps it also needs joined-up education. One regional office is inviting bids from collaboratives of educators and service providers to establish practice focused, interprofessional, and academically accredited education which will have a defined impact on improving outcomes for specified groups of patients.[21]

The intent of interprofessional education is not to produce khaki-brown generic workers. Its goal is better described by the metaphor of a richly coloured tapestry within which many colours are interwoven to create a picture that no one colour can produce on its own.

The UK Centre for the Advancement of Interprofessional Education (CAIPE) generated a list of principles of effective interprofessional education to stimulate debate and assist its development, implementation, and evaluation (see box at bottom of next page).[21] Since by definition interprofessional education occurs outside usual professional boundaries, it must be supported by strong representatives of each of the professions involved.

Effective interprofessional education

- Works to improve the quality of care
- Focuses on the needs of service users and carers

- Involves service users and carers
- Promotes interprofessional collaboration
- Encourages professions to learn with, from, and about one another
- Enhances practice within professions
- Respects the integrity and contribution of each profession
- Increases professional satisfaction

Focus on improvement

The need to make care more efficient (doing things right) and effective (doing the right things)[23] has produced some of the best examples of continuing professional development in the context of interprofessional collaboration. In addition to the Oxford study mentioned earlier, these include the Dorset Seedcorn Project in the United Kingdom and the Institute for Healthcare Improvement's Breakthrough Series in the United States. [24] [25]

In the Dorset Seedcorn Project, sponsored by Dorset Health Authority, five primary care practices agreed to join a six month collaborative effort to improve something of concern within the practice. Educational and technical support was provided by the Institute of Health and Community Studies at Bournemouth University.[24] Project teams were formed from natural work groups within the primary care practices; each established its own ground rules before beginning. Grant funds made it possible for each team to take three half-days away from the practice over the six month period. At a meeting of project teams to share their results, all reported progress. Examples included: a redesigned system for incoming telephone inquiries with improved service for patients and less hassle for staff; a new health visitor surgery for young children with acute illness, with improved access and a decreased prescribing rate; better ways to meet the needs of patients who were frequent attenders at surgery; and a new system to improve the quality of medical records and accuracy of medications for elderly people at a local residential home. All five practice teams also reported improved interprofessional understanding and communication.

Similarly in the Breakthrough Series, healthcare organisations from across the United States send interprofessional teams to participate in cross organisational collaboratives focused around specific health issues. Examples are reducing caesarean birth rates, improving outcomes and reducing costs in adult cardiac surgery, providing more effective care for low back pain, and improving asthma care in children and adults.[25] While the focus is on the specific issue at hand, there is also explicit attention to learning about interprofessional teamwork and testing change. The cost is borne by each team's home organisation. Many have seen sufficient results to sponsor teams in several areas.

For example, the Breakthrough collaborative for improving asthma care brought together interprofessional teams from 12 medical centres. In 15 months, nine achieved satisfying results.[25] One team working to reduce emergency department visits and hospital admissions for patients with asthma increased the rate of steroid prescriptions for asthma patients seen in the emergency department (consistent with national guidelines) and improved communication between the emergency department and the primary care clinic. The rates of hospital admissions and emergency visits for asthma patients at high risk decreased by 50%; use of the emergency department by all primary care clinic patients with asthma decreased by 25%.

Barriers to interprofessional collaboration and education

- Differences in history and culture
- Historical interprofessional and intraprofessional rivalries
- Differences in language and jargon
- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in requirements, regulations, and norms of professional education
- Fears of diluted professional identity
- Differences in accountability, payment, and rewards
- Concerns regarding clinical responsibility

In both the Dorset Seedcorn Project and the Breakthrough Series, the focus for each interprofessional group was on a specific patient need, one that the participants felt was particularly important in their own work site. The learning involved both theory and practice. By studying the processes of their work, the participants discovered some of the reasons for current unwanted results, quite apart from the personal characteristics of the professionals who worked in those processes. They were given the resources (especially their own time) and the support (not the least of which was a feeling of safety) to make changes based on what they had discovered. They generated hypotheses about improvement, made a change, studied the results, and thought together about what should happen next. Their teachers worked as coaches, helping them discover new knowledge as the project demanded it and assisting them as they explored and tackled the group dynamics that arose along the way. One of the teacher-facilitators from the Dorset Seedcorn Project wrote: "The experience of learning and discovering together created excitement and great debate. This engendered mutual respect and an understanding of actual interrelationships and interdependencies which had not been explicit previously. Crucially, they (all the teams) achieved, and it was they, not us."

Implications for continuing medical education

The examples above suggest a path for continuing medical education which combines the professional development and interprofessional collaboration needed for improved practice. Interprofessional groups working within their own practice sites found a shared goal around patient need and discovered together how to improve results. Such an approach requires a different investment of resources: teachers who can coach rather than lecture; professional time away as a work group rather than as individuals; opportunities to study current processes, design and test changes, and analyse the results; and the support of interprofessional education from the senior leadership of each of the professions involved, perhaps in exchange for time now spent in uniprofessional learning.

Schön wrote that what practitioners most need to learn is what professional education seems least able to teach.[26] He pointed out that much of professional education rests comfortably on the "high ground," where manageable problems lend themselves to solution through the application of research based theory and techniques. Unfortunately, the problems of greatest concern tend to lie in the "swampy lowland" of messy, confusing problems that defy technical solution. Broadening our vision of continuing medical education to include continuing professional development in the context of interprofessional collaboration and practice improvement may help

doctors and their professional partners find answers to the swampy problems most important to the health of their patients and communities.

Footnotes

- Series editors: Hans Asbjørn Holm and Tessa Richards

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