Chapter 12
Strengthening interprofessional practice

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Learning objectives

- Describe why rural and remote environments require effective, team-based, interprofessional approaches to health care.
- Identify appropriate knowledge, skills and attitudes for working effectively in rural health care teams.
- Recognise and describe ways in which effective interprofessional practice can be supported and improved.
- Develop a better understanding of the need for intersectoral collaboration in the provision of patient-focused health care.

Introduction

Ideally, health service provision is focused on the needs of the patient (or client) and their family. Effective health promotion, illness and injury prevention, diagnosis, treatment and palliation depend on the right services being available at the right time. Consequently, providing high-quality, sustainable and reasonably accessible health services for rural and remote Australians has become a national priority (AHMAC and NRHA 2002).

New models of health service delivery are being introduced to address issues such as the ageing population, increased specialisation and service access inequities, as well as the future workforce shortfall (Productivity Commission 2005). In 2003 and 2004, for example, the More Allied Health Services (MAHS) program funded more than 200 full-time equivalent rural allied health positions through the Australian Divisions of General Practice (DoHA 2004). This program aims to encourage linkages between allied health service providers and general practitioners. Under the Enhanced Primary Care (EPC) program, case conferences between a GP and at least two other health care providers have been allocated item numbers on the Medical Benefits Schedule. The EPC

program focuses on clients with chronic medical conditions and complex care needs requiring the services of a range of health professionals.

This chapter introduces the model of interprofessional and intersectoral team-based care. Interprofessional practice (IPP) is when practitioners from different professional backgrounds work together to improve the quality of patient care (Barr 2005). Instead of working independently within a loosely constituted ‘group’, health professionals work together as interdependent members of a ‘team’ to provide more holistic health care. IPP focuses on the importance of health professionals working collaboratively, often beyond the boundaries of traditional practice roles, to provide care to rural Australians. Intersectoral approaches involve working with other sectors (such as education, housing, industrial, legal and communication sectors) to produce the best outcome for improvements in individual and population health.

The case studies and exercises included in the chapter aim to develop awareness of the skills, knowledge and attitudes necessary for effective, team-based health care.

Case study 12.1 (a) Ageing in rural Australia: Burt and Lorraine’s story

Burt has just turned 74. He is a semiretired, third-generation farmer, who still lives on a cattle property. Lorraine married Burt 49 years ago and is three years younger. She gave up teaching to have their two children and then stayed home to help run the farm. She is more outgoing than Burt and enjoys regular contact with her friends and family.

Burt and Lorraine’s home is an old, single-storey timber farmhouse. Once quite grand, it has become increasingly run-down over recent years. The paint is peeling off the weatherboards, and a trip to the toilet means dodging the suspect boards on the back veranda, down several steps to the detached outhouse. The original claw-foot bath has lost much of its enamel and the shower above has become increasingly difficult for them to use. They have an electric hotplate, but the old oven, running hot water, and heating all rely on a steady supply of chopped wood. Like his father, Burt grew up on the farm, as did Burt and Lorraine’s children. They all worked hard over the years to make a living off the land, but as Lorraine often says, ‘We don’t have too much to complain about, we’ve still got our health’. Burt likes to point out that he hasn’t ‘seen a quack for 13 years’, since he broke his leg in a tractor accident.

Burt has had a bit of a cough almost as long as he or Lorraine can remember. His early morning ‘coughing fit’ is part of the daily routine. Afterwards, he has a smoke to ‘help clear the tubes’. Recently however, his cough has become more persistent and severe. Lorraine has been concerned about Burt’s cough and his recent lack of energy, a concern she has shared with their daughter.

Lorraine and Burt’s children, Susan and Wayne, are both now in their 40s and live in Conlow — a small town (population 2250) about 45 minutes’ drive away. It’s a two-hour drive to the nearest regional centre, Marnsdale (population 20 200). They don’t go there often, as Lorraine’s eyesight is deteriorating and Burt now does all the driving. Anyway, neither of them like ‘big towns’ with all the traffic and not knowing anyone so far from home. Burt takes Lorraine to Conlow each Saturday so she can do the shopping and have a cup of tea with their children.

Burt sometimes gets out to say g'day to Susan, but for shopping and visits to Wayne's house he waits grumpily in his old four-wheel drive smoking cigarettes, often with the car windows wound up.

Burt has not spoken to his son for several years, ever since Wayne refused to move back and help Burt run the farm. Burt had to sell off more than half the farm. He says this was due to a few below-average seasons, but he has also found it more and more difficult to keep up with all the manual work on his own.

Discussion

Like many ageing citizens, Burt and Lorraine are at the stage of their lives where their health care needs are becoming increasingly complex. It is unlikely that any single health professional can meet all their current or future health care requirements. Even highly accomplished clinicians will be limited by their knowledge and skills, and by their sphere and scope of practice. The pooled competencies of a diverse group of health professionals are needed to provide client-focused care for the ageing rural population.

There is a commonly held belief that established professional customs and practices should be questioned (Productivity Commission 2005). Rigid scopes of practice and closely guarded professional boundaries can be counterproductive to the delivery of high-quality health care. Rigid boundaries can also limit access to the professional skills, knowledge and resources available to address complex health care needs. The Productivity Commission's position paper, *Australia's Health Workforce*, recommended

workforce restructuring based on the need to increase interprofessional approaches in clinical practice and education (Productivity Commission 2005).

The commission also recognised that rural and remote health services are often an 'incubator' for new models of care that incorporate expanded scopes of practice and have the potential to inform future 'system-wide' changes (Productivity Commission 2005). The interdependence that develops in rural health services because of professional isolation, the shortage of specialist providers and the collaborative nature of rural practice means rural practitioners are often at the 'cutting edge' of change.

Indeed, the concept of adjusting practice roles to meet consumer needs is not entirely new in rural and remote health care. For example, delegation of authority in the nurse practitioner model of care has been observed to blur the traditional boundaries between rural GPs and nurses (Siegloff 1995, Hegney 1996, Roberts 1996). However, Bagg (2004) claimed that the nurse practitioner role has, for many years, been part of the duties of registered nurses working in rural public hospitals. It should be pointed out that, while exemplifying role or task substitution, the nurse practitioner model does not, by definition, require improved collaboration between health care practitioners — an essential element of IPP models of care.

Challenges for the learner and teacher

1. Considering their physical, mental and social wellbeing, what are Burt and Lorraine's most obvious health risk factors currently?
2. What health and social needs might Burt and Lorraine have in the coming years?
3. What choices might they need to consider to maintain their health and wellbeing, both now and in the future?
4. Taking into account accessibility, which health professionals do you believe would be best able to help Burt and Lorraine make choices about their current and future needs?

Case study 12.1 (b) Care options and interprofessional teamwork: Burt and Lorraine's story (continued)

One day, Susan is on the farm visiting her parents when Burt has a coughing fit that produces a quantity of fresh red blood. After about 20 minutes, he settles down a bit and they bundle him into the back of Susan's car and drive to Conlow Multipurpose Service. The bleeding seems to have slowed by the time they get there.

They are told he has ruptured a small blood vessel in one of his lungs. Burt spends five impatient days in hospital feeling 'pretty ordinary'. He has a blood test, a chest X-ray and a number of other tests. When he gets the reports from the doctor, Burt learns he has advanced lung cancer, and that soon he is going to become much sicker.

Burt is told to see the specialist who comes to Marnsdale once a fortnight. According to the GP, surgery is probably out of the question, so that leaves 'radiation' in Metropolis, the state capital, or 'chemo', which they might be able to organise in Marnsdale. Lorraine dabs her cheek with a handkerchief, trying not to let Burt see her tears. As she clutches his hand tightly, and he murmurs faintly, 'I'm sorry love. I don't want to leave you alone. I just couldn't hack it, though, going all the way to the city. Can we go home now?'

Discussion

One of the great strengths of IPP is that the composition of the team changes as the needs of the patient change. Also, where expert practitioners are in short supply, as is the case in many rural and remote locations, the role of team members may vary to include tasks outside their normal professional jurisdiction. For example, increasingly the tasks of general practitioners are being performed by practice nurses, allied health professionals or physician assistants. Care is centred more on the needs of the patient, rather than being profession-centred. Despite such variations in team composition and roles, the essential characteristics of successful health care teams remain the same, as do the factors that impede the performance of less successful teams.

Several authors have described the elements of successful collaborative practice (Norsen et al 1995, Lindeke and Block 1998, D'Amour et al 2005, San Martin-Rodriguez et al 2005). These are synthesised in Table 12.1, below. Norsen et al (1995) have further claimed that the elements of successful teams are bound together by trust between team members.

While the characteristics of successful health care teams have been elaborated, the known impediments to successful interprofessional practice have also been described (Manthorpe and Iliffe 2003):

- Team members may have differing levels of perceived status and prestige.
- The knowledge base of some team members may differ from that of others.
- Language and terminology may vary.
- Time and space constraints commonly exist.
- Focus and orientation (eg the value placed on teamwork versus individualism) can also differ among health professionals.

Increased interaction and communication has the potential to enable greater understanding of each other's roles and engender trust between team members. However, the challenge is to incorporate differing professional attitudes, beliefs, values and behaviours within a single organisational structure (Hall 2005). Negotiations may be obstructed or limited by societal issues of power, authority, education and socialisation (Lindeke and Block 1998), as well as by structural impediments, such as different lines of management (McCallin 2001), regulatory and legal obstacles (Lahey and Currie 2005), and a lack of shared space and time (Lindeke and Block 1998).

Table 12.1 Key elements of successful collaborative practice in health care

Cooperation
Collegial relations are based on equality. Shared decision making replaces hierarchical authority.
Commitment
Commitment to care forms the basis of task-focused working relationships. Collaborations are valued as the preferred option.
Assertiveness
Team members are able to express their views. Problems and possible solutions are communicated, maintaining harmonious working relationships.
Responsibility
Team members are accountable for their own viewpoint and support decisions made by consensus. They interact productively with colleagues from a range of disciplines and, if necessary, facilitate conflict resolution in the interests of the clients and the team.
Communication
Team members are accessible and open to the exchange of ideas. They are able to negotiate role boundaries, define the scope of practice and develop succinct standards, guidelines and protocols, thus establishing the 'boundaries of authority'. There is agreement about how best to achieve goals.
Autonomy
Team members trust each other to act independently and competently. They are aware of their own preferred and non-preferred ways of approaching tasks and can self-assess strengths and weaknesses. They have the capacity to interpret health care situations from the perspective of other health professionals and so avoid inappropriate autonomous practice.
Coordination
Practitioners are aware of the roles and capabilities of other health professionals and how others contribute to collaborative care. There is recognition of health issues that are best addressed interprofessionally. Individuals make efficient use of resources and organise the components of care appropriately.
Governance
Team members value and nurture interprofessional collaboration and engage in team building. Power is decentralised and delimited authority is delegated to individual health professionals, promoting a sense of joint ownership. There is an understanding of referral protocols and procedures.

Source: Adapted and modified from Norsen et al (1995), Lindeke and Block (1998), D'Amour et al (2005) and San Martin-Rodriguez et al (2005).

Challenges for the learner and teacher

1. If Burt and Lorraine choose to remain at home and allow the disease to 'run its course', which health professionals should be included on the health care team?
2. How would you suggest such a team of health professionals should be organised or structured?
3. In the context of this case study, what qualities, attitudes and behaviours would you expect the team to exhibit if it is to be highly effective?
4. What qualities, attitudes and behaviours do you believe would be detrimental to the effectiveness of the team?

Case study 12.2 Interprofessional collaboration and education: Jasmine's story

Jasmine (nine months old) presents to the emergency department of a small rural district hospital. She is brought in by her parents. A sibling (Errol), about three years old, accompanies them. Jasmine is lying in the stroller, legs in a frog-like posture and a bottle of formula that she is sucking on furiously clutched firmly in her right hand. Her left arm is lying limply by her side. The father steps forward and volunteers to the senior nurse on duty that Jasmine fell off the bed. 'She's hurt her arm', he says. The nurse has a gentle look and Jasmine turns her eyes in the direction of the nurse, stops sucking momentarily, then closes her eyes and starts sucking again, hard.

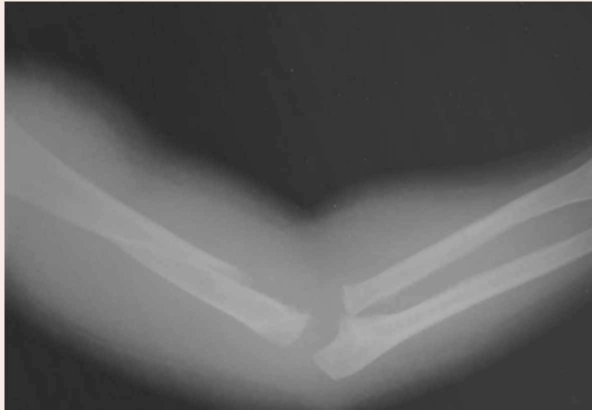
Because it's after hours, the local GP and the radiographer, who are both sole practitioners, are called in. The GP does a quick clinical examination and asks some questions of the parents about Jasmine's clinical history. He then requests 'a whole arm X-ray, shoulder to wrist'. Jasmine, both parents and young Errol all head off to the X-ray department with the radiographer. 'So what happened?' the radiographer asks. The father replies, 'Aw, she left Jasmine and him alone in the bedroom. He', the father points at Errol, 'was jumping on the bed. I just heard Jas scream and there she was on the floor. He probably knocked her off'. 'Yeah, or jumped on her', the mother adds.

The parents watch from a corner of the X-ray room as Jasmine is positioned for her X-ray. She is quiet, not crying. This strikes the radiographer as strange because, from the position and deformity, the child's humerus is definitely broken. There is tension emanating from the corner of the room where the parents are whispering in harsh tones to each other. Errol sits quietly on the floor, watching.

The radiographer notices what appears to be fairly recent finger-tip bruising on Jasmine's left shoulder and on both lower legs. She also observes that both children are thin and pale, even though Jasmine is still sucking strongly on the now almost empty bottle of formula. The radiographer takes a couple of views and turns to the parents, 'I'm going to process these. Can one of you look after her?' 'I will', says the mother. 'She can't!', the father snaps.

The film drops out of the processor and is put up on the viewer. The radiographer thinks to herself, 'Hmm, a spiral fracture of the humerus. Doesn't fit with the story of a fall. Spiral fracture — torsion'. In the view that shows the baby's shoulder, the radiographer sees two other abnormalities. Jasmine has had a broken clavicle, which appears to have healed satisfactorily,

and there are two, or perhaps three, previous rib fractures, no more than a month old. She returns to the X-ray room and says to the parents, ‘I’m just going to talk to the doctor. Back in a minute. By the way, has Jasmine been here before for X-rays?’ ‘No’, both parents reply in unison.



On talking to the doctor, it is agreed that for a child of this age to have multiple fractures at different stages of healing, with no previous medical record, is highly indicative of physical abuse (Hobbs 1989). It appears probable that Jasmine’s current injury, and perhaps the previous injuries as well, are non-accidental. ‘The authorities’ have to be notified.

Discussion

There is growing recognition of the need to design and implement context-appropriate, interprofessional and intersectoral approaches to health service delivery (Axelsson and Axelsson 2006). Intersectoral approaches involve working with other sectors (such as education, housing, industrial, legal and communication sectors) to produce the best outcome for improvements in population health. In Jasmine’s case, this requires collaboration between various health care professionals, the legal and judicial system and the state/territory community services. The education sector is also commonly involved in child protection cases involving school-aged children. Practitioners from all these sectors learn about child protection, but generally in monodisciplinary groups. Yet when a ‘notification’ occurs, they are expected to work together as a team, sharing a common interest in the best possible outcomes for a child like Jasmine.

Interprofessional education (IPE) is one potential way of addressing the need for collaborative care and protection in such cases. Similarly to IPP, practitioners from different disciplines learn with, from and about each other in order to improve collaboration and the quality of patient-focused health care (Barr 2005). IPE encompasses pre-service, or undergraduate education, as well as postgraduate and continuing education. It has been argued that, logically, effective IPE leads to better IPP (Stone 2006). There is growing international evidence that IPE can improve team-based health care in the management of a range of complex, chronic conditions, as well as acute care and health promotion. However, Cochrane and other reviews have concluded that there is a lack of valid experimental evidence, with too much methodological variation, to permit

sound conclusions to be drawn at this time about the effectiveness of IPE (Zwarenstein et al 2005). This is partly due to the intrinsically complex nature of IPE (Stone 2006), involving interaction and support from the health and education sectors, as well as from political and professional organisations. It may also be attributable to the difficulties of performing controlled trials in the face of ethical issues, including educational and health care equity. Nevertheless, the literature is overwhelmingly in favour of IPE supporting IPP initiatives (Barr 2005).

Challenges for the learner and teacher

1. Child protection crosses various sectors and involves a variety of professionals. Identify these sectors, the professionals involved, and some of the roles they might fulfil in the short and long term.
2. How might education play a role in decreasing the risk of such cases going undetected or resulting in an unsuccessful prosecution of the perpetrator(s)?

Key points

- Interprofessional team-based care is an essential aspect of rural health care provision. It focuses on the importance of health professionals working collaboratively, often beyond the boundaries of traditional practice models, to provide effective care to those living outside urban centres.
- A diverse but coordinated team of health professionals facilitates the provision of client-focused care by contributing various professional values, beliefs and range of skills and knowledge.
- Cooperation, commitment, assertiveness, shared responsibility, communication, autonomy, coordination and governance are essential for successful collaborative practice.
- Intersectoral collaboration is based on the same principles as interprofessional collaboration but draws on professions outside health care to provide holistic support to clients.
- The development of effective interprofessional practice depends partly on effective interprofessional education.

Recommended readings and resources

- Faresjo T (2006). Interprofessional education to break boundaries and build bridges. *Rural Remote Health* 6:602.

This paper discusses the potential of interprofessional education as a means of enhancing collaborative practice in the primary health care team, as well as the complexity of health care and the challenges for rural and remote populations.

- Hall P (2005). Interprofessional teamwork: professional cultures as barriers. *Journal of Interprofessional Care* Suppl 1(May):188–196.

This paper considers the influence of the different values, beliefs, attitudes, customs and behaviours of various health professionals on the development of team work. Educational, systematic and personal factors are discussed, as well as methods that could contribute to the development of effective interprofessional teams.

- Kenny G (2002). Children's nursing and interprofessional collaboration: challenges and opportunities. *Journal of Clinical Nursing* 11:306–313.

Challenges and opportunities inherent in interprofessional collaboration are discussed. Interprofessional practice is the foundation stone of the UK's integrated care system, and the goals include improving communication, managing risks and promoting holistic patient care. The paper considers professional, organisational, political and economic factors in the implementation of interprofessional practice.

- McNair R, Stone N, Sims J and Curtis C (2005). Australian evidence for interprofessional education contributing to effective teamwork preparation and interest in rural practice. *Journal of Interprofessional Care* 19(60):579–594.

The authors of this paper detail an interprofessional education program for undergraduate health science students undertaking placements in rural Victoria, Australia. Educational methods and student evaluation results are discussed.

- Cooke S, Chew-Graham C, Boggis C and Wakefield A (2003). I never realised that doctors were into feelings too: changing students' perceptions through interprofessional education. *Learning in Health and Social Care* 2(3):137–146.

The authors use 'breaking bad news' to explore the effectiveness of IPE on collaborative teamwork, communication skills and a holistic, interprofessional approach to patient care. Students learned that they needed to balance independent and collaborative responsibilities through a dynamic process of negotiation.

- Barr H (2005). *Effective Interprofessional Education: Arguments, Assumption and Evidence*, Blackwell, Oxford.

This text presents a systematic review of interprofessional education in health and social care, accompanied by a wider-ranging critique of interprofessional education, grounded in experience and informed by sources beyond the evaluations included in the review.

Learning activities

1. Taking either case study above as a starting point, work in an interprofessional group to create a flowchart or storyboard of an appropriate clinical pathway that may be followed. Identify stages where interprofessional collaboration would be most important, and identify opportunities for improving current practice.
2. Interprofessional practice requires political, educational and professional support. Discuss strategies that will support the development of interprofessional practice in rural and remote areas from each of these perspectives.
3. Make an appointment with a health professional from a discipline other than your own and spend some time discussing the relevance of teamwork to clinical practice. The eight elements of successful teamwork described in Table 12.1 can guide your discussion.
4. Spend at least half a day in a clinical department other than that of your own discipline and observe how other health professionals perform their duties.
5. Describe and discuss with your peers two clinical cases you have observed, one that demonstrates effective collaborative care, and another that demonstrates opportunities for teamwork to be improved.
6. If you or one of your family members lived in a remote area of Australia and had a terminal illness, what would the health care challenges be? How would you overcome these problems and what resources would you need?